

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card folders, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

173321										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17332																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
Rose R. Baseman										Dec. 19, 1968										9:30 P.M.																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										IF UNDER 1 YEAR MONTHS										IF UNDER 24 HRS. HOURS MIN.									
Female										White										Sept. 6, 1885										83 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
Maryland										U.S.A.																				Carroll Co., Md.																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Manchester										Longview Nursing Home										Housewife										Home																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																			
Maryland										Baltimore										Owings Mills																				223 Gwynnbrook Ave.																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
John Yox										Margaret Fredrick																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)										16b. SOCIAL SECURITY NO.										17. INFORMANT										1929 Whistler Avenue, Baltimore, Maryland 21230																													
No										212-48-5119										Earl Baseman																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART 1. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a)										Chronic Myocarditis																																																	
4129										DUE TO, OR AS A CONSEQUENCE OF																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Arteriosclerotic Cardiovascular Disease																																																	
										DUE TO, OR AS A CONSEQUENCE OF																																																	
(c)																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
4221																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 7-25, 1968, to 12-19, 1968, that (I) (we) last saw the deceased alive on 12-18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED																																																	
Joseph E. Bush M.D.										12-19-68																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
										Hampstead, Maryland.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										Dec. 23, 1968										Holy Family Church Cem.										Harrisonville, Balto. Md.																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
H. J. Ehrhardt										Owings Mills, Md.										DEC 23 1968										J. Charles, Jr.																													

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VR A15 (4)
30M REV. 1/68

17322										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17333									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
CLARENCE RUSSELL BELL										Month 12 Day 2 Year 68										27 M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
MALE			WHITE			APRIL 17, 1901			67 YRS.			MONTHS			DAYS														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
MARYLAND			U.S.A.						CARROLL Co.																				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)					12b. KIND OF BUSINESS OR INDUSTRY														
WESTMINSTER					CARROLL Co GEN. HOSP					CLERK, COUNTY ROADS DEPT.																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
MD.					CARROLL					WESTMINSTER					25 WESTMORELAND ST														
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16. SOCIAL SECURITY NO.										17. INFORMANT									
EDWIN D. BELL SR.					BARBARA EICHORN					213-01-9180-A					EDWIN D. BELL, JR., ADDRESS SAME														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT										Address									
NO					213-01-9180-A					EDWIN D. BELL, JR., ADDRESS SAME																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) 1621 BRONCHOGENIC CARCINOMA - RUL -																													
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																													
(b) WITH EXTENSIVE INVOLVEMENT OF BOTH LUNGS															6 mos.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																													
1621																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 12/1, 1968, to 12/2, 1968, that (I) (we) last saw the deceased alive on 12/2 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE															22c. DATE SIGNED														
[Signature] MD DEGREE															12/2/68														
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
BURIAL					12/5/68					WESTMINSTER CEMETERY WESTMINSTER MD.																			
24. FUNERAL DIRECTOR															25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE									
J.S. Myers Jr. Westminster, Md.															DEC 6 1968					[Signature]									

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VR A15
30M REV. 1-68

17323

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17334

1. DECEASED-NAME (Type or print) First Middle Last John Crogan Bennett			2a. DATE OF DEATH Month 11 Day 1968 Year 1968		2b. HOUR 1:10 P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH Aug. 16, 1896		6. AGE (In years last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Co., Md.	
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Co. Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Buyer - Western Elect. Co.		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Carroll	13c. CITY OR TOWN Westminster	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 166 David Ave.	
14. FATHER'S NAME First Middle Last Oliver Bennett		15. MOTHER'S MAIDEN NAME First Middle Last Naomi Crogan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI & WWII		16b. SOCIAL SECURITY NO. 215-10-4064	17. INFORMANT Dorothy Bennett 166 David Ave. Westminster, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured aortic aneurysm</u> 4419 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 022X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 11, 1968</u> , to <u>Dec 11, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Dec 11, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (didn't) view the body after death.					
22b. SIGNATURE <u>John S. Harshey, MD</u> DEGREE				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE, SIGNED 12/11/68
22d. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY MD		22e. ADDRESS 8 Archer St. Westminster, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec. 14, 1968	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Pikesville, Balto., Md.	
24. FUNERAL DIRECTOR <u>H. J. Ellhardt</u>		ADDRESS Owings Mills, Maryland		25a. REC'D BY REGISTRAR DEC 13 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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VR A 500
30M REV. 1-68

17324

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17335

1. DECEASED-NAME (Type or print) First ANNA Middle P. Last BOHRER			2a. DATE OF DEATH Month Dec. Day 5 Year 1968			2b. HOUR 8 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 19, 1891		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.				
10. CITY OR TOWN OF DEATH Mt. Airy			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Box 325			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Telephone Operator			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 325	
14. FATHER'S NAME First William Middle T. Last Harry			15. MOTHER'S MAIDEN NAME First Mary Middle Ann Last Boone							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 216-05-8827			17. INFORMANT Address Miss Sheila Bohrer Same As #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral thromboses DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years - 2 weeks										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (the hospital) attended the deceased from 10/20 , 19 63 , to 12/5 , 19 68 , that (I) (we) last saw the deceased alive on 12/5 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE James P. Kerr M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 12/6/68				
22d. PHYSICIAN'S NAME (Type) Dr. James P. Kerr						22e. ADDRESS Damascus, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12/9/1968			23c. NAME OF CEMETERY OR CREMATORY Damascus Cemetery			23d. LOCATION (City or Town) (County) (State) Damascus, Montgomery, Md.	
24. FUNERAL DIRECTOR ADDRESS C.M. Waltz, Box 241, Sykesville, Md.						25a. REC'D BY REGISTRAR DATE DEC 10 1968		25b. REGISTRAR'S SIGNATURE f Charles Judge		

MEDICAL CERTIFICATION

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VR A15
30M REV. 11-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) ROSELLA SAYLOR BOND			2a. DATE OF DEATH Month Dec. Day 13 Year 1968			2b. HOUR 5P M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 12/9/1879		6. AGE (In years last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS 89 DAYS 89 HOURS 89 MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md.			
10. CITY OR TOWN OF DEATH NEW WINDSOR		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BOARDING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE MARYLAND		13b. COUNTY FREDERICK		13c. CITY OR TOWN JOHNSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER UNION BRIDGE MD	
14. FATHER'S NAME First JOHN H. Middle SAYLOR Last SAYLOR			15. MOTHER'S MAIDEN NAME First SARAH Middle DIEHL Last DIEHL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes give year or dates of service)		16b. SOCIAL SECURITY NO. 218-32-3143		17. INFORMANT ROY G. BOND		Address: UNION BRIDGE, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Arteriosclerotic CVD DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ... DUE TO, OR AS A CONSEQUENCE OF (c) ...								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/27/68 , 19 68 , to 12/13/68 , 19 68 , that (I) (we) lost saw the deceased alive on 12/12/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M.E. Robertson MD					DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/13/68
22d. PHYSICIAN'S NAME (Type) M.E. ROBERTSON					22e. ADDRESS New Windsor, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12/16/1968		23c. NAME OF CEMETERY OR CREMATORY BEAVER DAM CEM		23d. LOCATION (City or Town) (County) (State) FREDERICK COUNTY, MD			
24. FUNERAL DIRECTOR W. H. Hightower					ADDRESS UNION BRIDGE, MD		25a. REC'D BY REGISTRAR DEC 17 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div style="display: flex; justify-content: space-between;"> 17328 CERTIFICATE OF DEATH 17337 </div>											
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR		
First Middle Last						Month Day Year			HOUR MIN		
Francis Asbury Boston Jr.						12-20-68			7:00 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		01-10-95		73 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Carroll		Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield State Hospital			Brakeman					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INS. OF CITY LIMITS?		13e. STREET AND NUMBER	
Maryland						Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		844 W. 37th St.	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Francis A. Boston				Anna Murphy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO		17. INFORMANT Address					
no				717-07-8164		Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										Days	
IMMEDIATE CAUSE (a) Heart failure											
4129 DUE TO, OR AS A CONSEQUENCE OF										Years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) Arteriosclerotic heart disease											
DUE TO, OR AS A CONSEQUENCE OF										Day	
(c) Bronchopneumonia											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
421											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from 12-17-1968, to 12-20-1968, that (I) (we) last saw the deceased alive on 12-20-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Paul G. Ensor, M.D.										12-20-68	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		12/23/68		Woodlawn		Baltimore					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Paul E. [Signature]						DEC 23 1968		[Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17327

17338

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR A M		
RUSSELL			EDWARD		BOYER	DECEMBER 5, 1968			3:35		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS HOURS MIN	
Male		White		5-11-10		58 YRS.					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH		
Pennsylvania			U.S.A.						Carroll Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield State Hospital			Odd Jobs					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore City			Baltimore		YES		No fixed address	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Ralph					Boyer	Katie					Dundore
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT Address					
No			Unknown			Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home farm street factory office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>6-24-68</u> , 19__, to <u>12-5-68</u> , 19__, that (I) (we) last saw the deceased alive on <u>12-5-68</u> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Octavio A. Ruiz M.D.</u> DEGREE						ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 12-5-68		
22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.						22e. ADDRESS Springfield State Hospital Sykesville, Md. 21784					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Funeral			Dec. 9, 1968			St. Mary's Cemetery					
24. FUNERAL DIRECTOR <u>Frank J. Howell</u>			24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			24c. REC'D BY REGISTRAR DEC 16 1968			24d. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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17328

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) KATIE GLADYS BREHM			2a. DATE OF DEATH Month DEC Day 23 Year 1968			2b. HOUR 2:00 M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH APRIL 16 1899		6. AGE (In years last birthday) 69 YRS		F. UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (State or foreign country) CARROLL, MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md.			
10. CITY OR TOWN OF DEATH RFD WESTMINSTER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital street address) ROUTE #4		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) PRACTICAL NURSE		12b. KIND OF BUSINESS OR INDUSTRY HOSPITAL			
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE MARYLAND		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER ROUTE #4	
14. FATHER'S NAME First JOHN J. Middle BREHM Last BREHM			15. MOTHER'S MAIDEN NAME First EMMA Middle LEISTER Last LEISTER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 214-07-1645		17. INFORMANT LELA BREHM Address SISTER SAME ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 174X DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA BREAST DUE TO, OR AS A CONSEQUENCE OF (c) 8 YEARS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 DAYS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 174X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from DEC 1958 to DEC 1968 , that (I) (we) last saw the deceased alive on DEC 23 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Daniel I. Welliver M.D. DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-23-68		
22d. PHYSICIAN'S NAME (Type) DANIEL I. WELLIVER M.D.					22e. ADDRESS WESTMINSTER MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/26/68		23c. NAME OF CEMETERY OR CREMATORY Leister Cemetery		23d. LOCATION (City or Town) (County) (State) Westminster, Carroll, Md.			
24. FUNERAL DIRECTOR E. E. Myers, Jr., Westminster, Md.					25a. REC'D BY REGISTRAR DEC 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

NO

JOHN J.

BREHM

514-01442

LETA BREHM

EMMA FEISTEN

STATE ADDRESS

7

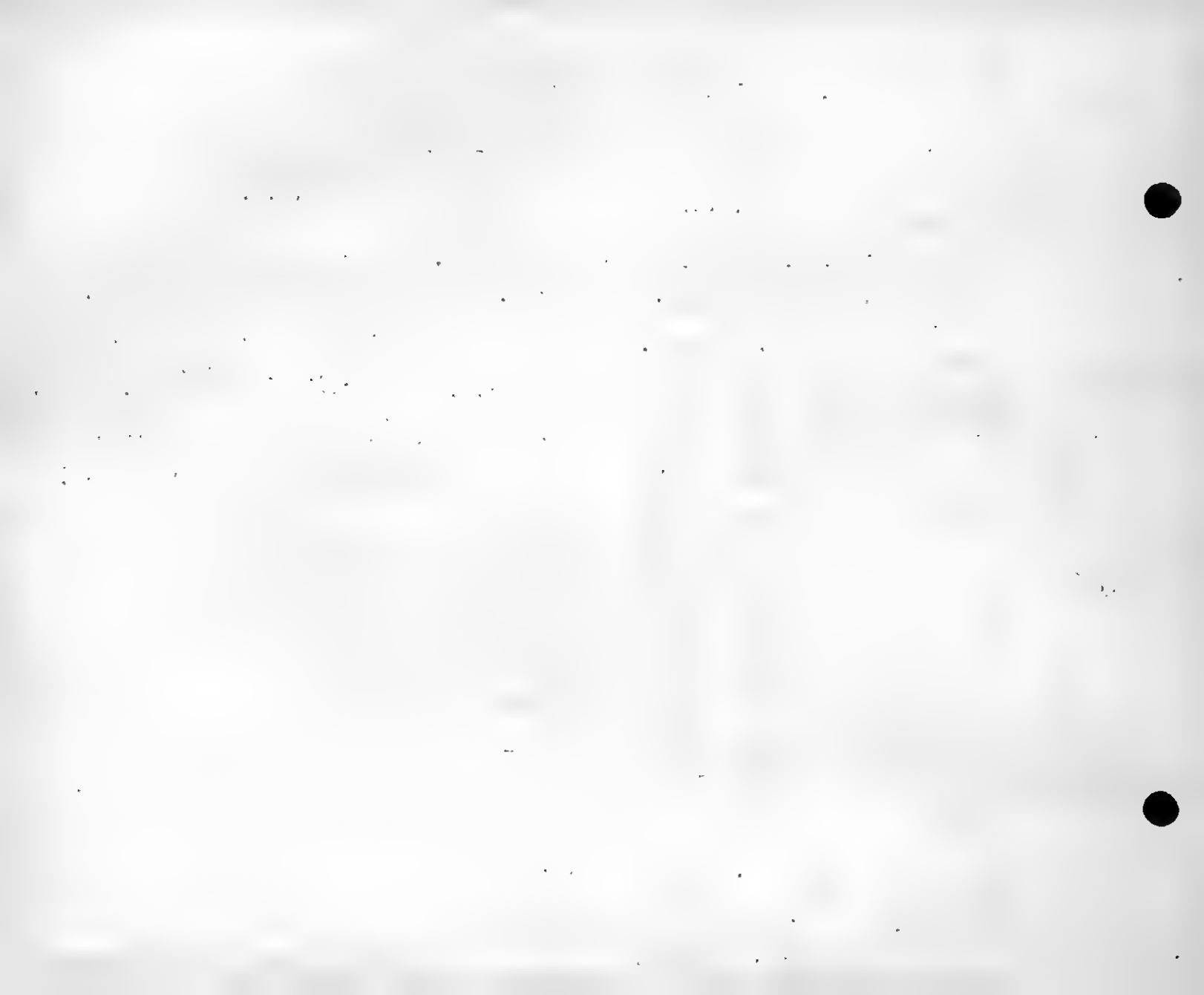
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VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
17329											
17340											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) John ^{First} Ellsworth ^{Middle} Brockman ^{Last}						2a. DATE OF DEATH 12 ^{Month} 9 ^{Day} 68 ^{Year}		2b. HOUR 9 PM			
3 SEX Male		4 RACE White		5. DATE OF BIRTH 3-30-1910		6. AGE (in years last birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH V. Carroll Md.					
10. CITY OR TOWN OF DEATH Sykesville, Md.		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Springfield State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE MD.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2720 Jefferson St.			
14. FATHER'S NAME First Middle Last George W. Brockman				15. MOTHER'S MAIDEN NAME First Middle Last Louise M. Pitz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		(If yes give year or dates of service) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Louise M. Brockman Mother 2720 Jefferson St. Balto. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Minutes											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201 Epilepsy											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 7-24-1959, to 12-10-1968, that (I) (we) last saw the deceased alive on 12-10-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Gracito V. Patricio				DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/10/68			
22d. PHYSICIAN'S NAME (Type) Gracito V. Patricio M.D.				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/13/68		23c. NAME OF CEMETERY OR CREMATORY Pierwood Cemetery		23d. LOCATION (City or Town) Baltimore		(County) Maryland		(State)	
24. FUNERAL DIRECTOR HENRY SANDER & SONS INC. BALTIMORE MARYLAND				ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 13 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

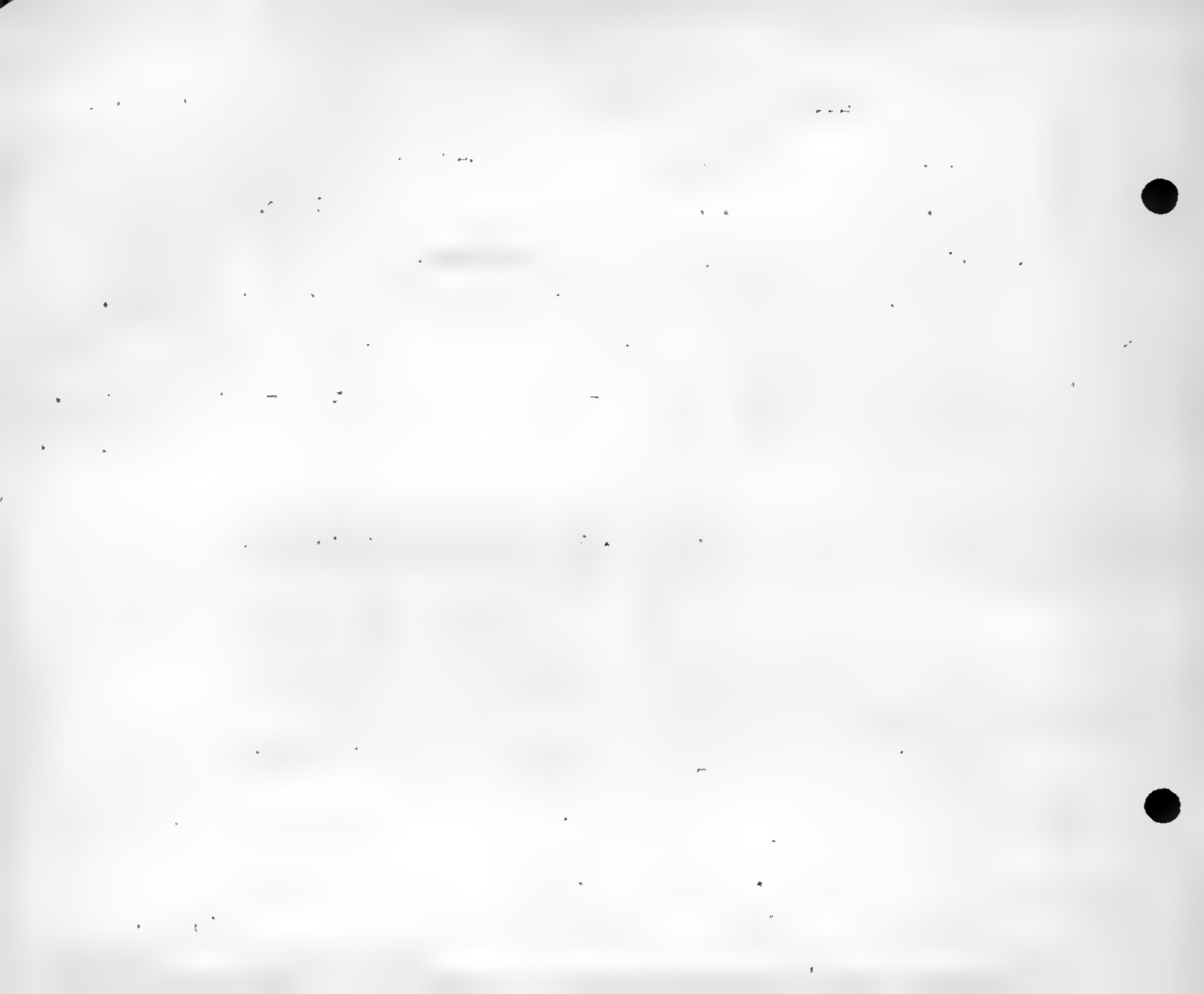
MEDICAL CERTIFICATION



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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
17330 CERTIFICATE OF DEATH 17341												
1. DECEASED-NAME (Type or print) Brown Irene Pauline Brown						2a. DATE OF DEATH Month 12 Day 5 Year 68			2b. HOUR 11:30 P. M.			
3. SEX female		4. RACE negro		5. DATE OF BIRTH 3-22-01			6. AGE (In years last birthday) 87 YRS.		7. UNDER 1 YEAR MONTHS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll Md.					
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) cook			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2115 Walbrook Ave.		
14. FATHER'S NAME First Middle Last Elma Cross				15. MOTHER'S MAIDEN NAME First Middle Last Mary Marshall								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no				16b. SOCIAL SECURITY NO. 212-22-0238		17. INFORMANT Hospital Records - Springfield Hosp.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4317 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) CBS assoc. with cerebral arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 334												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 11-18 , 19 68 , to 12-5 , 19 68 , that (I) (we) lost the deceased alive on 12-5 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Paul G. Enos						DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 5 Dec 68		
22d. PHYSICIAN'S NAME (Type) Paul G. Enos						22e. ADDRESS Baltimore, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-10-68		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.						
24. FUNERAL DIRECTOR V.R. Bailey						25a. REC'D BY REGISTRAR DEC 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				
Kelson Funeral Home 1348 Calhoun St.												



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17331

17342

1 DECEASED NAME (Type or print) PHILOMENA CLEMENTINE BRYTE			2a DATE OF DEATH Month 12 Day 19 Year 68			2b HOUR 8¹⁰ A M								
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH APRIL 23, 1919		6. AGE (In years last birthday) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN 				
7a BIRTHPLACE (State or foreign country) BALTO. MD.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL CO. Md.								
10. CITY OR TOWN OF DEATH WESTMINSTER			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4 OAK AVE.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE-WIFE			12b. KIND OF BUSINESS OR INDUSTRY 					
13a USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE MARYLAND			13b. COUNTY CARROLL			13c CITY OR TOWN WESTMINSTER			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER 4 OAK AVE.		
14. FATHER'S NAME First Middle Last STANISLAUS J. LEWANDOWSKI			15. MOTHER'S MAIDEN NAME First Middle Last KLEMENTYNA ZAMBRZKA											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) YES (If yes give war dates or service) 43-45			16b SOCIAL SECURITY NO 212-16-9977			17 INFORMANT WAYNE H. BRYTE,			Address SAME ADDRESS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 4109 DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CORONARY HEART DISEASE YEARS DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMED.				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 420														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)								
21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 1963 to 12/19, 1968 , that (I) (we) last saw the deceased alive on 12/18, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE Vincent J. Fiocco Jr.						22c DATE SIGNED 12/19/68								
22d. PHYSICIAN'S NAME (Type) VINCENT J. FIOCCO JR.						22e ADDRESS ANCHOR ST. WESTMINSTER, MD								
23a B. RIAL, CREMATION, REMOVAL (Specify)			23b DATE 12/23/68			23c NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY			23d LOCATION (City or Town) (County) (State) BALTIMORE MD					
24. FUNERAL DIRECTOR J. S. Myers, Jr., Westminster Md.						25a REC'D BY REGISTRAR DEC 23 1968			25b. REGISTRAR'S SIGNATURE Charles Judge					

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17332

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17343

1. DECEASED-NAME (Type or print) Evelyn Virgie Pollard Burdette			2a. DATE OF DEATH Month 12 Day 23 Year 68			2b. HOUR 4:45 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 7-11-1900		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield St. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Laytonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER P.O. Box 1002	
14. FATHER'S NAME First Frank Middle Pollard Last			15. MOTHER'S MAIDEN NAME First Allie Middle UNKNOWN Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None		16b. SOCIAL SECURITY NO. 579-40-3321		17. INFORMANT Address Springfield St. Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident 4367 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 337X (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (the hospital) attended the deceased from 11-29-68 , 19____, to 12-23-68 19____, that (I) (we) lost saw the deceased alive on 12-23-68 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Paul G. Ensor, M.D.					DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-23-68
22d. PHYSICIAN'S NAME (Type) Paul G. Ensor, M.D.					22e. ADDRESS Springfield St. Hosp. Sykesville, Md.				
23a. BURIAL (Cremation, Burial) Burial		23b. DATE Dec. 27 1968		23c. NAME OF CEMETERY OR CREMATORY Laytonsville St. Pauls		23d. LOCATION (City or Town) (County) (State) Laytonsville Mont. Md			
24. FUNERAL DIRECTOR Francis H. Barber					ADDRESS Laytonsville Md		25a. REC'D BY REGISTRAR DEC 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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18

17333

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17344

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last Samuel David BARRY			2a. DATE OF DEATH Month <u>17</u> , Day <u>1968</u> Year		2b. HOUR <u>1:15</u> P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH 6-30-04		6. AGE (In years lost birthday) 64 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) West Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Carroll County, Md.		
10. CITY OR TOWN OF DEATH Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Balto. City	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3530 Lynchester Road	
14. FATHER'S NAME First Middle Last Samuel Barry			15. MOTHER'S MAIDEN NAME First Middle Last Marie Schwartz		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (if yes give war or dates of service) No		16b. SOCIAL SECURITY NO None	17. INFORMANT Address Records, Springfield State Hospital		
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 450X DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary emboli Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Minutes
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 465X					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-10-</u> , 19 <u>68</u> to <u>12-17</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-17</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Octavio A. Ruiz</i>			DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED 12-17-68	
22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.			22e. ADDRESS Sykesville, Maryland 21784 Springfield State Hospital		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/20/68	23c. NAME OF CEMETERY OR CREMATORY Parkwood	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Maryland			25. REC'D BY REGISTRAR DEC 19 1968 DATE		



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17345
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)			First Julia	Middle Madeline	Last Carey	2a. DATE OF DEATH 12 Month 10 Day 68 Year			2b. HOUR 1:40 PM			
3 SEX female		4 RACE white		5 DATE OF BIRTH 8/30/87		6 AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.						
10. CITY OR TOWN OF DEATH Rural--Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) millinery			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution an residence before admission) STATE Md.				13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6805 Brennan Lane		
14. FATHER'S NAME			First Patrick	Middle -	Last Holmes	15. MOTHER'S MAIDEN NAME			First Katie	Middle -	Last Sheridan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no				16b. SOCIAL SECURITY NO. 577-16-5055		17. INFORMANT Address Springfield Hospital records, Sykesville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Pyelonephritis, right kidney										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Weeks Years Days - weeks		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that he (this hospital) attended the deceased from 3/21/1968 to 12/10/1968 , that he (we) last saw the deceased alive on 12/10/1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (d) did not view the body after death												
22b. SIGNATURE Renato R. Espina						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/10/68				
22d. PHYSICIAN'S NAME (Type) Renato R. Espina, M. D.						22e. ADDRESS Springfield State Hospital Sykesville, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12-13-68		23c. NAME OF CEMETERY OR CREMATORY State of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring Md						
24. FUNERAL DIRECTOR Francisco Calles		ADDRESS 500 University Blvd W Silver Spring, Md		25a. REC'D BY REGISTRAR DEC 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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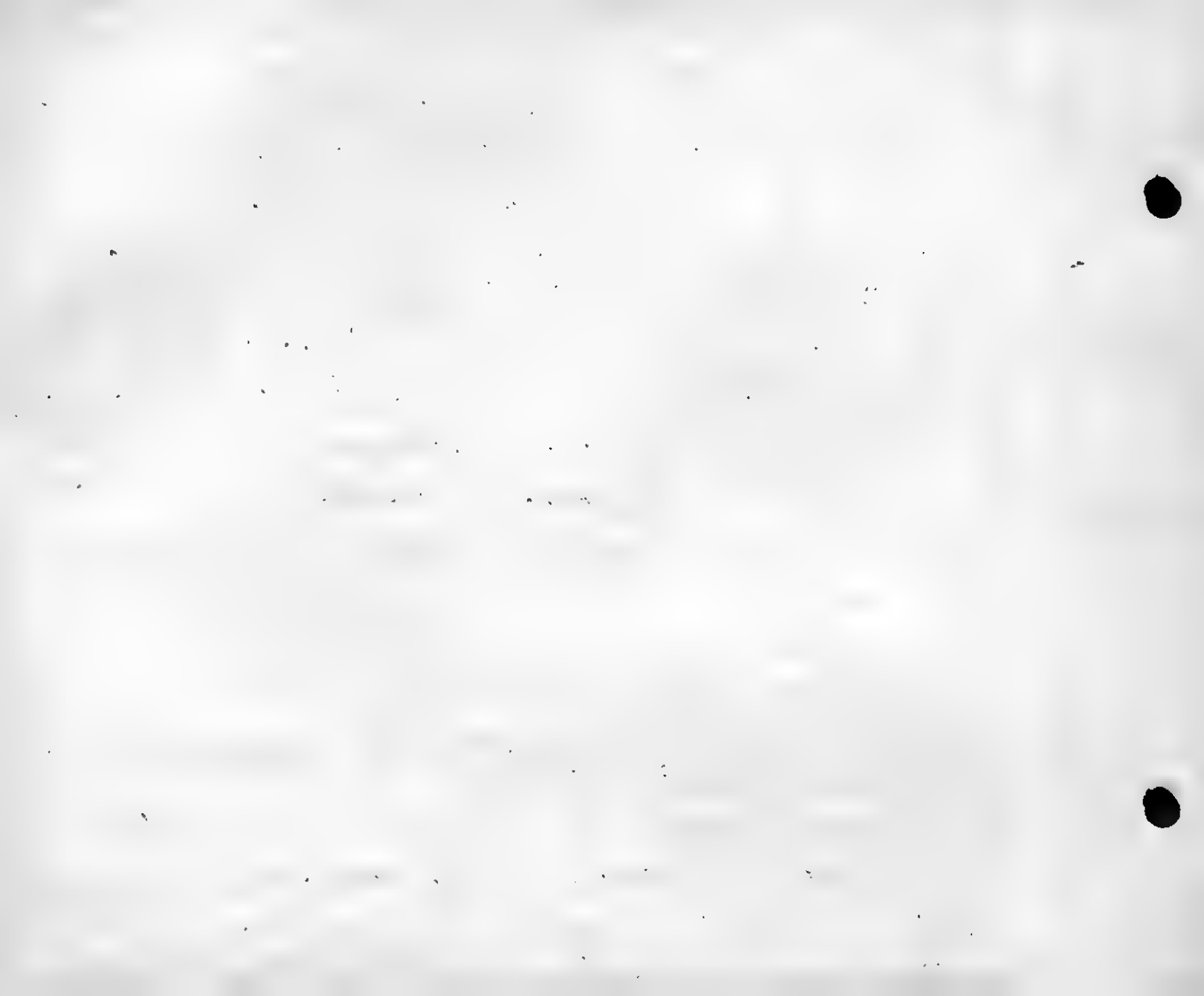
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH			2b HOUR		
Mabel L. Chamberlin						Month 12 Day 38 Year 68			12 P M		
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 24 HRS		
Female		White		May 7, 1887			81 YRS.		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md.		
Va.		USA				Carroll					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Westminster			Carroll Co. Hospt.			Housewife					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY, MTS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Md.			Carroll			Westminster			13e STREET AND NUMBER		
									114 Washington Rd.		
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME						
First Middle Last					First Middle Last						
William Chamberlin					Margaret Davis						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			Address		
NO			215-14-1172A			Mrs. Hellen Siegman			Westminster, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA</u>										3 HOURS	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u>										36 HOURS	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ATHEROSCLEROTIC CORONARY HEART DISEASE</u>										YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Trauma											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		Hour A.M. Month Day Year									
		P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION				Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/27, 1968</u> to <u>12/28, 1968</u> , that (I) (we) lost saw the deceased alive on <u>12/28, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE						22c. DATE SIGNED					
<u>Wincent J. Kucera MD</u>						12/28/68					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Dec. 31, 1968		Mt. Hebron Cemetery		Winchester, Va.					
24 FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Tipton - Eline Funeral Home Hampstead, Md.						DATE DEC 31 1968		<u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M. REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
173386											
17347											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR		
JOHN			CHRIST III.			Dec. 9, 1968			1:40 A.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
Male			White			Jan. 27, 1910			58 YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
N. J.			U. S. A.			CARROLL			Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Finksburg			Louisville Rt 32			FOREMAN			Rental CAR		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Md.			CARROLL			Finksburg			Route 32		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
John - Christ II			Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
Yes			U. S. A.			MR Palmer Miller			Finksburg, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA - TERMINAL</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF PROSTATE</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 WK</u> <u>3-4 mos.</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>11/18</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 22, 1968</u> , to <u>Dec. 9, 1968</u> , that (I) (we) last saw the deceased alive on <u>12/8</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED		
MARTIN E. STROBEL									12/9/68		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
MARTIN E. STROBEL			REISTERSTOWN, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			12-12-68			Lakewood Cemetery			Lakewood, Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Harry W. Haight			Lakewood, Md.			DATE DEC 12 1968			J. Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
17348											
1. DECEASED NAME (Type or print)			First S. Middle (Clairborne) Last (Clairborne)			2a. DATE OF DEATH Month Day Year			2b. HOUR		
William (X) (Clairborne)						December 10, 1968			4:25 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		N negro		10-16-96		72 YRS.		MONTHS DAYS		HOURS M-N	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Virginia			USA						Carroll Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield St. Hospital			Dishwasher					
13a. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Balto. City			Baltimore				1016 Arlington Avenue	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
H enderson Clairborne			Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Address					
Unknown			213-07-4220			Springfield St. Hospital Records					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease										Years	
4129 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis										Years	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
422											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11-14-68, 19__, to 12-10-68, 19__, that (I) (we) last saw the deceased alive on 12-10-68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS		
Glocrito G. Sagisi			12-10-68			Glocrito G. Sagisi			Springfield St. Hospital Sykes, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			12/13/68		Arbutus Mem. Park			Arbutus, Maryland			
24. FUNERAL DIRECTOR ADDRESS						25a. DEC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Charles A. Rice 661 W. Barre St.						DEC 12 1968		Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon orders, pages 1 and 2, and 4, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) John			First Harman			Middle Clark			Last		
2a DATE OF DEATH Month Dec Day 20 Year 1968			2b HOUR 11:30 M								
3 SEX Male			4 RACE Negro			5 DATE OF BIRTH May 19, 1887			6 AGE (In years last birthday) 81		
						8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll Co., Md.		
7a BIRTHPLACE (State or foreign country) Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.A.								
10 CITY OR TOWN OF DEATH Westminster			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll County Gen.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Truck Driver			12b. KIND OF BUSINESS OR INDUSTRY Local Haul		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Owings Mills			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
13e STREET AND NUMBER 65 Featherbed Lane											
14 FATHER'S NAME First William Middle Henry Last Clark			15. MOTHER'S MAIDEN NAME First Rachel Middle Blake Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO 216-03-1820			17 INFORMANT Mrs. Viola Flemming Reisterstown, Md.			Address: Rt. #3 Box 2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 332X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Dec 13, 1968 , to Dec 20, 1968 , that (I) (we) last saw the deceased alive on Dec 20, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John S. Harshey, MD			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 12/20/68		
22d. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, MD			22e. ADDRESS 8 Anchor St. Westminster, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Dec. 23, 1968			23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Ch. Cem.			23d. LOCATION (City or Town) (County) (State) Owings Mills, Balto. Md.		
24. FUNERAL DIRECTOR H. J. Schlueter			ADDRESS Owings Mills, Md.			25a. REC'D BY REGISTRAR DEC 23 1968			25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR	
Grace J. Dell						Dec. 16 1968		1:30 M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		Dec. 5, 1902		66 YRS.			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		USA				Carroll		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Westminster		Carroll Co. Hospt.		Housewife		Home			
13a USUAL RESIDENCE (Where deceased lived, admission) STATE		13b COUNTY		13c. CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Carroll		Finksburg				Rt. 1	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
James Abbott			Garafiola Hare						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17 INFORMANT				
NO			216-44-1137		Woodrow Dell Rt. 1 Finksburg (Son)				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>									
4109 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 14</u> , 19 <u>68</u> , to <u>Dec 16</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 16</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <u>John S. Harshey</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12/16/68		
22d. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>					22e. ADDRESS <u>8 Archer St. Westminster Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		Dec. 19, 1968		Wesley Cemetery		Hampstead Carroll Co. Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Tipton - Eline Funeral Home Hampstead, Md.					DEC 20 1968		<u>J Charles Judge</u>		

CERTIFICATE OF DEATH

17310

17351

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. DECEASED NAME (Type or print) <u>GOTTFRIED</u>			First Middle Last			2a. DATE OF DEATH <u>Dec</u> Month <u>11</u> Day <u>8</u> Year <u>68</u>			2b. HOUR <u>4P</u> M					
3 SEX <u>M</u>			4. RACE <u>W</u>			5. DATE OF BIRTH <u>May 25, 1887</u>			6. AGE (In years last birthday) <u>81</u> YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <u>Switzerland</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>Carroll</u> Md.					
10. CITY OR TOWN OF DEATH <u>Sykesville</u>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Mineral Hill Rd. Sykesville</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Machineist</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Machine</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE <u>Md.</u>			13b. COUNTY <u>CARROLL</u>			13c. CITY OR TOWN <u>SYKESVILLE</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <u>MINERAL HILL RD.</u>		
14. FATHER'S NAME <u>ZAK MARIAS</u>			First Middle Last			15. MOTHER'S MAIDEN NAME <u>EGWI</u>			First Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>NO</u>			(If yes give war or dates of service) <u>None</u>			16b. SOCIAL SECURITY NO <u>715-01-4297A</u>			17. INFORMANT <u>Mrs. Lucia Herwig, Mineral Hill Rd. Sykesville</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma, metastatic, site, source</u>														
1991 DUE TO, OR AS A CONSEQUENCE OF <u>unknown</u>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF <u>unknown</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>ASCVD, cardiomyopathy</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>4 August</u> , 19 <u>64</u> , to <u>Dec 11</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5 Dec</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Charles H. Williams MD.</u>			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>11 Dec 68</u>					
22d. PHYSICIAN'S NAME (Type) <u>Charles H. Williams M.D.</u>			22e. ADDRESS <u>P. Kesville, 41208, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>Dec. 14, 1968</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Mendowridge Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Baltimore</u>					
24. FUNERAL DIRECTOR <u>Frank H. Newell</u>			ADDRESS <u>Pikesville, Md.</u>			25a. REC'D BY REGISTRAR <u>DEC 13 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
17341						17352							
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print) <u>Minnie Jane Elgen</u>						2a. DATE OF DEATH <u>12</u> Month <u>13</u> Day <u>68</u> Year						2b. HOUR <u>2:5</u> M	
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>June 13, 1881</u>		6. AGE (In years last birthday) <u>87</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <u>md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Carroll</u> Md.							
10. CITY OR TOWN OF DEATH <u>Manchester, md.</u>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Longview Nursing Home, Inc.</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Home - wife</u>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <u>md.</u>				13b. COUNTY <u>Carroll</u>		13c. CITY OR TOWN <u>Westminster</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>113 Liberty St.</u>			
14. FATHER'S NAME First <u>Thomas</u> Middle <u>Tanner</u> Last <u>Tanner</u>				15. MOTHER'S MAIDEN NAME First <u>Rachel</u> Middle <u>Richardson</u> Last <u>Richardson</u>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>no</u> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <u>220-46-4781</u>		17. INFORMANT <u>med. H. H. H. 922 R. and St.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF <u>& decompensation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary & Mitral Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>5-12, 1968</u> , to <u>12-13, 1968</u> , that (I) (we) last saw the deceased alive on <u>12-13-68</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>William Speiker</u> DEGREE <u>MD.</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>12-13-68</u>							
22d. PHYSICIAN'S NAME (Type) <u>Westminster Md</u>						22e. ADDRESS <u>Westminster Md</u>							
23a. BURIAL, CREMATION, REMOVA (Specify)		23b. DATE <u>12/16/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		23d. LOCATION (City or Town) <u>Westminster</u> (County) <u>Carroll</u> (State) <u>Md.</u>							
24. FUNERAL DIRECTOR <u>E. E. Myers, Jr.</u> ADDRESS <u>Westminster, Md.</u>						25a. REC'D BY REGISTRAR <u>DEC 17 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



3



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17332

17353

1. DECEASED-NAME (Type or print) Nellie Rebecca Ensor			2a. DATE OF DEATH December 27, 1968		2b. HOUR 6:00 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH 7-13-91		6. AGE (In years last birthday) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County, Md.	
10. CITY OR TOWN OF DEATH Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housekeeper		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Balto. City	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 704 Cator Avenue	
14. FATHER'S NAME Samuel L. Ensor			15. MOTHER'S MAIDEN NAME Fleanor Harmon		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 213-36-0533A		17. INFORMANT Records, Springfield State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 4:29 IMMEDIATE CAUSE (a) Mesenteric thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4:22 (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CPS, associated with cerebral arteriosclerosis with psychotic reaction					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 8-22-1964 , to 12-27-1968 , that (I) (we) lost saw the deceased alive on 12-27-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Paul G. Ensor, M.D.				22c. DATE SIGNED 12-27-68	
22d. PHYSICIAN'S NAME (Type) Paul G. Ensor, M.D.				22e. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12-30-68		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem	
23d. LOCATION (City or Town) (County) (State) Pikesville Balto Co Md					
24. FUNERAL DIRECTOR Burgess Funeral Home Balto Md		25a. REC'D BY REGISTRAR DEC 31 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First LUCILLE	Middle (NMN)	Last EVERHART	2a. DATE OF DEATH Month Day Year DECEMBER 4, 1968		2b. HOUR 5:30 A.M.	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 6-1-1889		6. AGE (in years last birthday) 79 YRS		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4108 Fairview Ave.	
14. FATHER'S NAME First Middle Last Armstead Watkins			15. MOTHER'S MAIDEN NAME First Middle Last Leeanna Unk.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 108-26-9445		17. INFORMANT Address Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4221</u>								APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH Days Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CBS assoc. with cerebral arteriosclerosis, with psychotic reaction									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>12-11-66</u> , 19__, to <u>12-4-68</u> , 19__, that (I) (we) last saw the deceased alive on <u>12-4-68</u> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <u>Dr. Antonius Glahn</u> DEGREE					ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-4-68		
22d. PHYSICIAN'S NAME (Type) Antonius Glahn, M. D.					22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12/7/68		23c. NAME OF CEMETERY OR CREMATORY Carver Mem PK		23d. LOCATION (City or Town) (County) (State) Laurel Md.			
24. FUNERAL DIRECTOR 1827 W. North Ave Baltimore, Md. Earl Baltimore Funeral Home					25a. REC'D BY REGISTRAR DATE DEC 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17344										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17355									
1 DECEASED-NAME										2a. DATE OF DEATH										2b. HOUR									
First Middle Last Mollie S. Eyler										Month 22, Day 68 Year										M									
3. SEX Female			4. RACE White			5. DATE OF BIRTH Jan. 3, 1892			6. AGE (In years last birthday) 76 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN														
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll Co. Md																				
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Grand View Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY																				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Balto.			13c. CITY OR TOWN Reisterstown			13d. INSIDE CITY LIM TSP YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER Main Street																	
14. FATHER'S NAME First Middle Last Francis Glenn Saffell			15. MOTHER'S MAIDEN NAME First Middle Last Mary Owings			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No, no, or unknown (If yes give war or dates of service)										16b. SOCIAL SECURITY NO 217-09-6678			17. INFORMANT Address Mrs. Alice Christhill Owings Mills, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gas kinase disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 yrs</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4.1 <u>Influenza infection</u>																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>																				
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from 1-1-1968 to 12-22-68, that (I) (we) lost the deceased alive on 12-18-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE James G. Saffell MD										ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 12. 24-68																
22d. PHYSICIAN'S NAME (Type) James G. Saffell										22e. ADDRESS Reisterstown, Balto Md																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Dec. 24, 68			23c. NAME OF CEMETERY OR CREMATORY All Saints			23d. LOCATION (City or Town) (County) (State) Reisterstown, Md.																				
24. FUNERAL DIRECTOR J. F. Cline & Sons Reisterstown, Md.										25a. REC'D BY REGISTRAR DEC 27 1968			25b. REGISTRAR'S SIGNATURE Charles Judge																

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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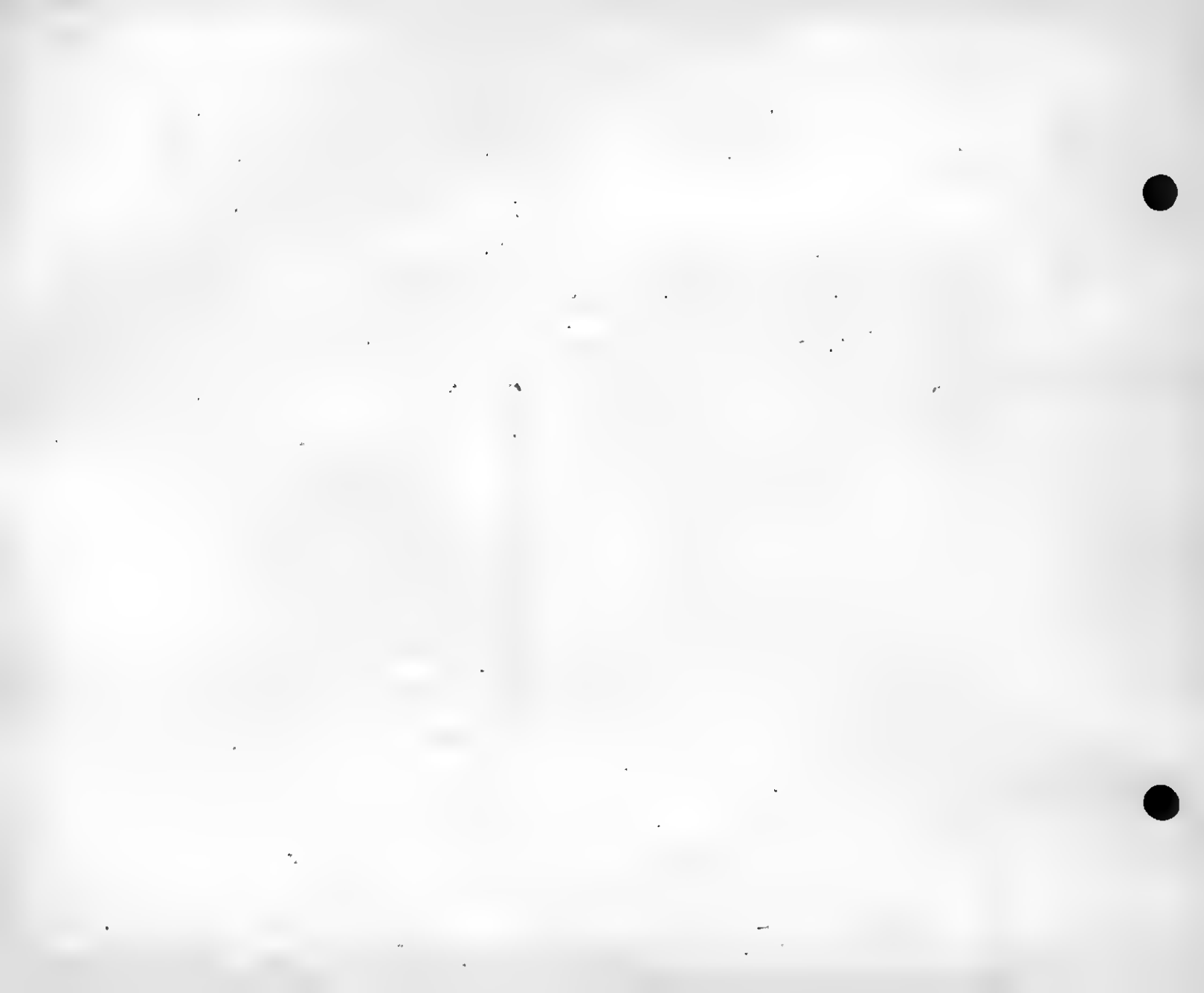
17315

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17356

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <u>Arthur</u> First <u>Ferguson</u> Middle <u>Ferguson</u> Last			2a. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>68</u>			2b. HOUR <u>5:00 PM</u>	
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>4-14-07</u>		6. AGE (In years last birthday) <u>61</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Carroll</u> Md.	
10. CITY OR TOWN OF DEATH <u>Sikesville Md</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Springfield State Hosp.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u>		13b. COUNTY <u>MONTGOMERY</u>		13c. CITY OR TOWN <u>GAITHERSBURG</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <u>ARTHUR</u> Middle <u>MMN</u> Last <u>FERGUSON</u>		15. MOTHER'S MAIDEN NAME First <u>SALLIE</u> Middle <u>-</u> Last <u>POWELL</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>NO</u>		16b. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT <u>HISTORY RECORD SHEET.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>NATURAL CAUSES, CORONARY</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>(PER DR. HAPNER'S NOTE)</u> (c) <u>(Miles), R.N.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>TIME: 5 PM</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) <u>NONE</u>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>5-16</u> , 19 <u>55</u> , to <u>12-27</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>DECEMBER 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Isaiah Hapner</u>		22c. DATE SIGNED <u>12-27-68</u>		22d. PHYSICIAN'S NAME (Type) <u>ISAK E. HAPNER</u>		22e. ADDRESS <u>SPRINGFIELD STATE HOSPITAL</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-27-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		23d. LOCATION (City or Town) (County) (State) <u>Gaithersburg Montg. Md.</u>	
24. FUNERAL DIRECTOR <u>Ernest E. Gartner</u>		25a. REC'D BY REGISTRAR <u>Ernest E. Gartner</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 3 1969</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print) <u>Christina D. Fethe</u>						2a. DATE OF DEATH Month <u>Dec.</u> Day <u>1</u> Year <u>1968</u>			2b. HOUR <u>4:15 AM</u>			
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>8-25-82</u>			6. AGE (In years last birthday) <u>86</u> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>United States</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <u>Carroll</u>			Md.		
10. CITY OR TOWN OF DEATH <u>Sykesville, Md</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Springfield State Hospital</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>factory</u>			12b. KIND OF BUSINESS OR INDUSTRY _____				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) <u>Maryland</u>		13b. COUNTY <u>Baltimore City</u>		13c. CITY OR TOWN <u>Baltimore</u>		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>3639 Dorsey Lane</u>				
14. FATHER'S NAME First <u>Charles</u> Middle _____ Last <u>Fethe</u>				15. MOTHER'S MAIDEN NAME First <u>Margaret</u> Middle <u>Bardroff</u> Last _____								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <u>220-54-6294</u>		17 INFORMANT <u>Katherine Denbo</u> Address <u>2011 Woodlawn Dr.</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Rheumatic Heart Disease (Chronic)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Years</u> <u>Years</u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>if /</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____								
22a. I certify that (I) (this hospital) attended the deceased from <u>3-1-1916</u> , to <u>12-1-1968</u> , that (I) (we) last saw the deceased alive on <u>12-1-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Gracito V. Patricio</u>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12/1/68</u>				
22d. PHYSICIAN'S NAME (Type) <u>Gracito V. Patricio, M.D.</u>						22e. ADDRESS <u>Springfield State Hosp. Maryland</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>12/4/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cmn. Trcl. Rd. Balt</u>			23d. LOCATION (City or Town) (County) (State) <u>Sykesville Md.</u>					
24. FUNERAL DIRECTOR <u>Farley Covanough</u>						25a. BY REGISTRAR DATE <u>DEC 6 1968</u>		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

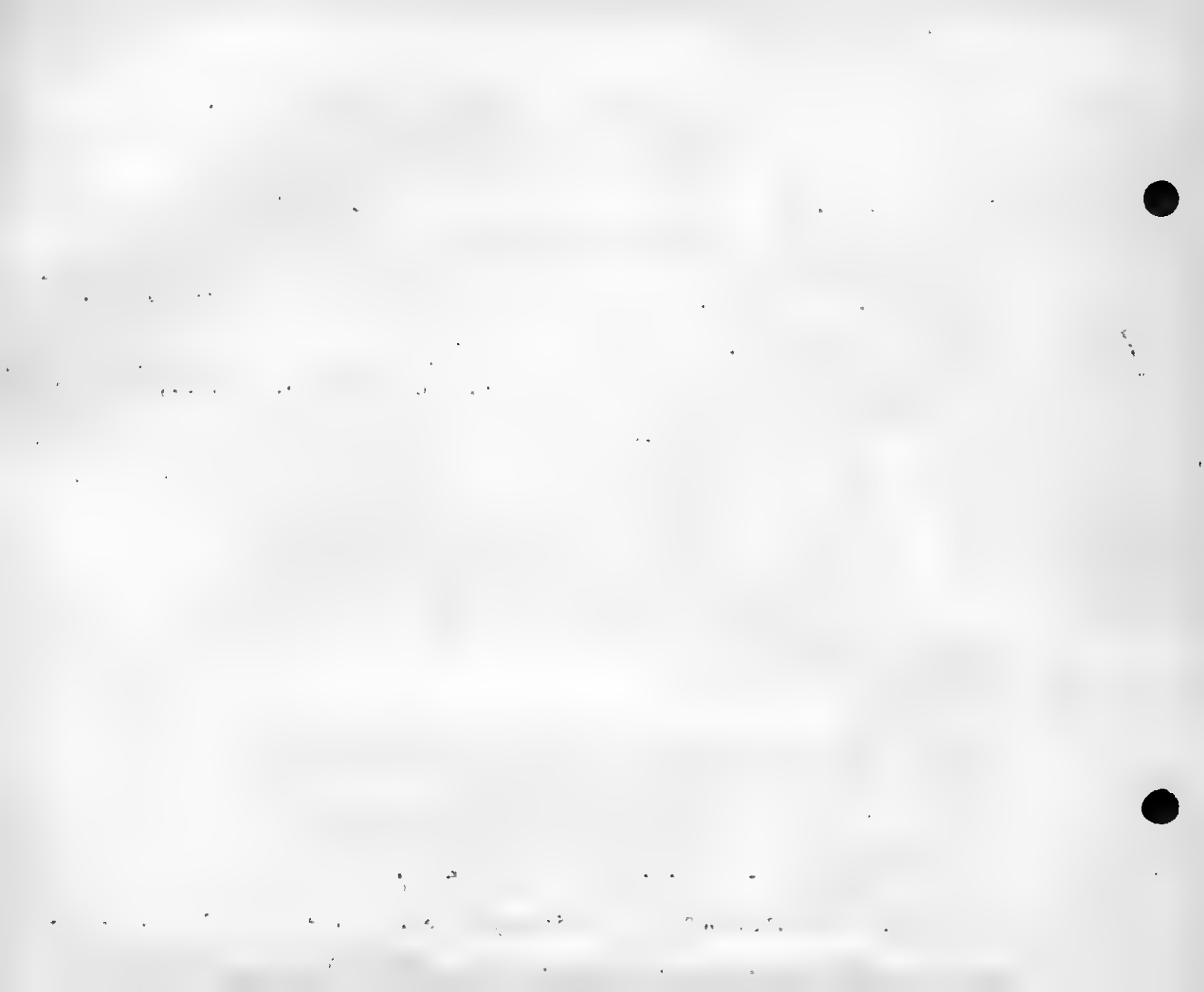
17317

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17358

1. DECEASED-NAME (Type or print) First M'ddle ? Last PANZI VIVIAN FINK			2a. DATE OF DEATH 12 Month 16 Day 68 Year		2b. HOUR M
3 SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH May 9, 1882		6 AGE (in years last birthday) abt 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Frederick, Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Carroll Md		
10. CITY OR TOWN OF DEATH Winfield	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) GOLDEN AGE NURS. HOME	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE	12b. KIND OF BUSINESS OR INDUSTRY NONE		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY Carroll	13c. CITY OR TOWN Westminster	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Route 5 Taylorsville Rd.	
14. FATHER'S NAME First Middle Last Jerome N. Pompelle		15. MOTHER'S MAIDEN NAME First Middle Last (Unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO (If yes give war or dates of service)	17 INFORMANT: son Wm. L. Fink, Taylorsville, Rd., Westminster, Address Carroll Co., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 421 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Second year Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 12/12, 1968, to 12/16, 1968 , that (I) (we) last saw the deceased alive on 12/15, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Harry Deibel M.D.				22c. DATE SIGNED 12/19/68	
22d. PHYSICIAN'S NAME (Type) Harry Deibel M.D.		22e. ADDRESS 1226 S. Hanover Street			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE Dec. 18, 1968	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	23d. LOCATION (City or Town) (County) (State) Pikesville, Balto. Co., Md.		
24. FUNERAL DIRECTOR STEWART & MOWEN CO. 108 W. North Av. Balto. 1		25a. REC'D BY REGISTRAR DEC 18 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Gorman papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30A REV. 11-68

17318

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17359

1 DECEASED NAME (Type or print) First Middle Last Robert Buchanan French, Jr.			2a DATE OF DEATH Month Day Year December 18, 1968 Year		2b. HOUR 8:50PM
3 SEX Male	4. RACE White		5. DATE OF BIRTH 7-4-89		6. AGE (In years last birthday) 79 YRS.
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Carroll County, Md.					
10 CITY OR TOWN OF DEATH Sykesville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Painter	
12b KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Washington		13c. CITY OR TOWN Hagerstown	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 36 Nottingham Road			
14. FATHER'S NAME First Middle Last Robert Buchanan French, Sr.			15 MOTHER'S MAIDEN NAME First Middle Last Katy Taylor		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b SOCIAL SECURITY NO. 213-16-1927		17. INFORMANT Address Records, Springfield State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u> 4124 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years Years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1201					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-6-</u> , 1968, to <u>12-18</u> , 1968, that (I) (we) last saw the deceased alive on <u>12-16-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Glocrito Sagisi				22c DATE SIGNED 12-18-68	
22d. PHYSICIAN'S NAME (Type) Glocrito Sagisi, M.D.				22e. ADDRESS Springfield State Hospital	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE DEC. 21, 68		23c NAME OF CEMETERY OR CREMATORY Salem Reformed Cem.	
23d LOCATION (City or Town) (County) (State) Cearfoss (Wash.) Md.					
24. FUNERAL DIRECTOR A. K. Coffman Funeral Home Inc.		ADDRESS 40 E. Antietam St. Hagerstown Md.		25a REC'D BY REGISTRAR DEC 26 1968	
25b REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last Clara Elizabeth Lingeman FREY						2a. DATE OF DEATH Month Day Year December 24 1968			2b. HOUR M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 1-6-81		6. AGE (In years lost birthday) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County, Md					
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland				13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME First Middle Last Henry B. Lingeman						15. MOTHER'S MAIDEN NAME First Middle Last Isabelle Lowe					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO		17. INFORMANT Address Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gangrene of right leg</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease with</u>											
DUE TO, OR AS A CONSEQUENCE OF <u>severe peripheral insufficiency</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED											
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)											
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19											
21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)											
21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>11-16</u> , 19 <u>68</u> , to <u>12-24</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>12-24-68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Dr. Antonius Glahn</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>											
22c. DATE SIGNED <u>12-24-68</u>											
22d. PHYSICIAN'S NAME (Type) <u>Antonius Glahn, M.D.</u>											
22e. ADDRESS <u>Springfield State Hospital</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>											
23b. DATE <u>Dec. 27, 1968</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>											
23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u>											
24. FUNERAL DIRECTOR <u>Howard County Funeral Home of Harry Witzke</u>											
25a. REC'D BY REGISTRAR <u>DEC 27 1968</u>											
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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17350										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17361																																							
1 DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR A																																							
James Carlin Fulton										December 24, 1968										12:05 PM																																							
3. SEX Male										4 RACE White										5 DATE OF BIRTH February 11, 1888										6 AGE (in years lost birthday) 80 YRS										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
7a BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH CARROLL Md																													
10. CITY OR TOWN OF DEATH SYKESVILLE										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRINGFIELD STATE HOSP.										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None										12b. KIND OF BUSINESS OR INDUSTRY																													
13a USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE Maryland										13b COUNTY Baltimore Co.										13c CITY OR TOWN Balto.										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e STREET AND NUMBER 101 Forest Drive																			
14 FATHER'S NAME First Middle Last WILLIAM FULTON										15. MOTHER'S MAIDEN NAME First Middle Last EIMA CARLIN																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? No										16b SOCIAL SECURITY NO. 220-56-9557-J										17 INFORMANT Hospital Records										Address																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia										DUE TO, OR AS A CONSEQUENCE OF (b) Cardiovascular Heart Disease with																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200										DUE TO, OR AS A CONSEQUENCE OF (c)																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) CBS assoc. with circulatory disturbance with cerebral art. without qualifying phrase																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM STREET FACTORY OFFICE BUILDING ETC)										21f. LOCATION Street or R.F.D. No City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 10/15/1957 to 12/24/1968, that (I) (we) last saw the deceased alive on 12/24/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE G. Patricio, M. D.										22c. DATE SIGNED 12/24/68																																							
22d. PHYSICIAN'S NAME (Type) G. Patricio, M. D.										22e. ADDRESS Springfield State Hospital																																																	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial										23b. DATE 12-26-68										23c. NAME OF CEMETERY OR CREMATORY ST Johns										23d. LOCATION (City or Town) (County) (State) ELlicott City Md.																													
24. FUNERAL DIRECTOR Higginbotham Slack										ADDRESS ELlicott City, Md.										25a. REC'D BY REGISTRAR DEC 31 1968										25b. REGISTRAR'S SIGNATURE J. Charles Judge																													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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17351

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17362

1. DECEASED-NAME (Type or print) Pearl Clifton Twigg GILPIN			2a. DATE OF DEATH Month Day Year December 7, 1968			2b. HOUR m. 12:30				
3. SEX female		4. RACE white		5. DATE OF BIRTH 7-28-1879		6. AGE (in years lost birthday) 89 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.				
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Howard Co		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route #3 21771		
14. FATHER'S NAME First Middle Last Louis Twigg			15. MOTHER'S MAIDEN NAME First Middle Last Nora Webster							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) <input checked="" type="checkbox"/> No			16b. SOCIAL SECURITY NO. 216-05-8840		17. INFORMANT Address Springfield State Hosp. Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary embolism</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriolosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes Years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>CBS assocd with senile brain disease with behavioral reaction.</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>8-21-67</u> , 19 <u> </u> , to <u>12-7-68</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>12-7-68</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE <u>Octavio A. Ruiz</u>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-8-68				
22d. PHYSICIAN'S NAME (Type) Octavio Ruiz, M.D.				22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21781						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 10, 1968		23c. NAME OF CEMETERY OR CREMATORY Poplar Springs Meth.		23d. LOCATION (City or Town) (County) (State) Poplar Springs, Md.				
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.				25a. RECD BY REGISTRAR DATE DEC 12 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
		MAURICE	EDWARD	GRAY	Dec 24 1968			7 P M	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
M	W		MARCH 12 - 1902		66 YRS.				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND	USA				CARROLL Md				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
WESTMINSTER	GENERAL		LABOR WELDER		RAILROAD				
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND	CARROLL		UNION BRIDGE				145 MAIN ST.		
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
CHARLES E			GRAY	EMMA				MYERS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT Address					
NO		705-10-6742		PAULINE GRAY UNION BRIDGE MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201 Cerebral Vascular accident									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 23, 1968</u> , to <u>Dec 24, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 24, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John S. Harshey, M.D.</u> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>12/24/68</u>		
22d. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>					22e. ADDRESS <u>8 Anson St. Westminster, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		12/27/68		MT VIEW		UNION BRIDGE MD			
24. FUNERAL DIRECTOR <u>D D Hartzler's Sons Union Bridge</u> ADDRESS					25a. REC'D BY REGISTRAR DATE <u>DEC 30 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
17364									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
NORA			EVA. GRIMES			DECEMBER 25 1968			8:45 PM
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		7. UNDER 1 YEAR MONTHS DAYS	
Female		White		JAN 20 1887		81 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA.				Carroll Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Manchester		Long View Nursing Home		Housewife		Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission), STATE		13b. CITY OR TOWN		13c. INSIDE CITY - LOTS?		13d. STREET AND NUMBER			
Maryland		Carroll Middleburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		NONE			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Charles Bowman			Rachel Flickinger						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT Address			
No			212 24-5973			Mrs. Carrie C. Saylor Union Bridge Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4120 Cerebral Vascular Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardio Vascular Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12-23-68	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
443									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Dec 13, 1968, to Dec 25, 1968, that (I) (we) last saw the deceased alive on Dec 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
Joseph E. Bush		Dec 25, 1968		Joseph E. Bush MD					
22e. ADDRESS		22f. ADDRESS							
Hampstead Maryland		Hampstead Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12/28/68		Methodist Cem		Middleburg MD			
23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE							
DEC 31 1968		Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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17354												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												17365											
1. DECEASED NAME (Type or print)												2a. DATE OF DEATH												2b. HOUR											
First				Middle				Last				Month				Day				Year				PM											
Mary				Elizabeth L.				Gunzelman				12				4				68				1:25											
3. SEX				4. RACE				5. DATE OF BIRTH				6. AGE (In years birthday)				IF UNDER 1 YEAR MONTHS				IF UNDER 24 HRS. HOURS MIN															
female				white				7/26/90				78				YRS.																			
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH																							
Maryland				USA								Carroll				Md.																			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY																							
Rural--Sykesville				Springfield State Hospital				dressmaker																											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER																			
Md.								Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				451 N. Milton Avenue																			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																															
First Middle Last				First Middle Last																															
George				- Gunzelman				Margaret				-				Dietz																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO				17. INFORMANT				Address																							
no				220-54-3010				Springfield Hospital records, Sykesville, Md.																											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 1. DEATH WAS CAUSED BY:												minutes																							
IMMEDIATE CAUSE (a) Cardiac arrest																																			
DUE TO, OR AS A CONSEQUENCE OF												years																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 4/2/72																																			
(b) Arteriosclerotic cardiovascular disease																																			
DUE TO, OR AS A CONSEQUENCE OF																																			
(c)																																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																			
Schizophrenic reaction, hebephrenic type.																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																											
				HOUR A.M. Month Day Year P.M. 19																															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION				Street or R.F.D. No. City or Town County State																							
22a. I certify that he (this hospital) attended the deceased from 3/20/1947 to 12/4/1968, that we (we) lost saw the deceased alive on 12/4/1968, and that in our (our) opinion death occurred on the date and hour and from the causes stated above, he (we) did (did not) view the body after death.																																			
22b. SIGNATURE				DEGREE				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22c. DATE SIGNED																							
Renato R. Espina												12/4/68																							
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS																															
Renato R. Espina, M. D.				Springfield State Hospital																															
				Sykesville, Maryland																															
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)																							
Burial				12/7/68.				Holy Redeemer Cemetery				Baltimore, Md.																							
24. FUNERAL DIRECTOR				ADDRESS				25a. DECEASED REGISTERED 1968				25b. DECEASED'S SIGNATURE																							
Leonard J. Nuck, Inc.				Md. 21214																															



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1

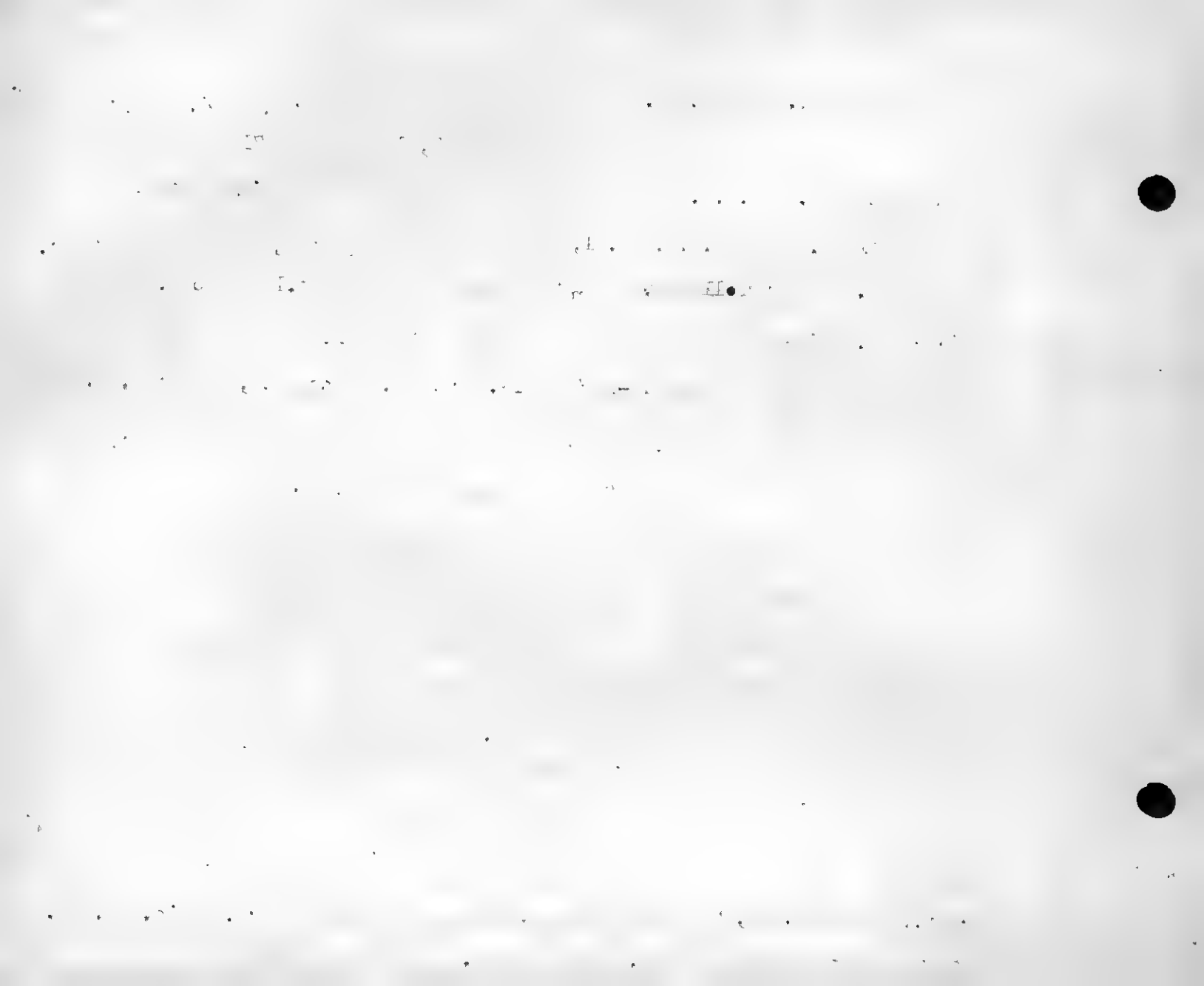
17355

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17366

1. DECEASED-NAME (Type or print) James B. Haines Sr.			2a. DATE OF DEATH Month Dec Day 18 Year 1968			2b. HOUR 5:00 PM	
3. SEX M		4. RACE White		5. DATE OF BIRTH June 27, 1897		6. AGE (in years last birthday) 71 YRS	
7a. BIRTHPLACE (State or foreign country) Staunton Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Carroll Md.	
10. CITY OR TOWN OF DEATH New Windsor Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.F.D. Rt. 1, New Windsor		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Printer		12b. KIND OF BUSINESS OR INDUSTRY Self Emp.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. COUNTY Carroll		13b. CITY OR TOWN New Windsor		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. 1 Box 96 A. 21176	
14. FATHER'S NAME First Robert O. Middle Haines Last Haines			15. MOTHER'S MAIDEN NAME First Ella Middle Dox Last Staples				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 413-14-1207		17. INFORMANT Address New Windsor Mrs. Ester L. Haines Rt. 1, Box 96 A.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the sigmoid DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma - sigmoid DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Year							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 7/30/68 to 12/18/68 , that (I) (we) last saw the deceased alive on 12/18/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. E. Robertson M.D.				22c. DATE SIGNED 12/18/68		22d. PHYSICIAN'S NAME (Type) M. E. Robertson	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 21, 68		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Park		23d. LOCATION (City or Town) (County) (State) Liberty Rd. Balto Co. Md.	
24. FUNERAL DIRECTOR Loring Byers 8728 Liberty Rd. Randallstown.				25a. REC'D BY REGISTRAR DEC 23 1968		25b. REGISTRAR'S SIGNATURE Charles J. Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/68

17356

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17367

1. DECEASED-NAME (Type or print)			First	Middle	Last	20. DATE OF DEATH			2b. HOUR		
William			Walter	Hare, Sr.	Dec.	Month	Day	Year	4 P.M.		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		7. UNDER 24 HRS	
Male		Cau.		May 26, 1897		71 YRS.		MONTHS		DAYS	
70. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md.		U.S.A.				Baltimore Co. Carroll Co. Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Hampstead			R.F.D. Upper Beckleysville Rd.			Farmer			Farm		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.			Baltimore			Hampstead			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER			R.F.D. Upper Beckleysville Rd.								
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Theodore L. Hare			Della V. HARE Fair								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT Address					
NO			220-03-2947			Donald E. Hare Dave Rill Rd. Hampstead, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Infarction</u>										34 hr.	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Insufficiency</u>										14 yr.	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Old Cardiac Infarction</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4201											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6-5, 1959, to 12-5, 1968, that (I) (we) last saw the deceased alive on 12-30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE										22c. DATE SIGNED	
M.C. Porterfield										12-6-68	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS	
M.C. Porterfield										Hampstead, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			Dec. 8, 1968			St. Abraham's Luth. Church			Hampstead Balto. Md.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
John E. Goff			324 N. Main St.			DATE DEC 9 1968			Charles Judge		
John E. Goff Funeral Home			Hampstead, Md.								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17357

17368

1 DECEASED NAME (Type or print) Forrest Glen Harrison			2a. DATE OF DEATH Dec. 30, 1968			2b. HOUR 5:45 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MARCH 8, 1886		6 AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (State or foreign country) Ohio		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md.				
10 CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Route 32			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Auto	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.			13b. COUNTY CARROLL		13c. CITY OR TOWN Sykesville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route 32	
14. FATHER'S NAME First Middle Last Charles - Harrison			15 MOTHER'S MAIDEN NAME First Middle Last Rosella - Shook							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) -			16b SOCIAL SECURITY NO 214-05-5378		17 INFORMANT Address Mrs. Vesta Harrison - Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma colon, with liver DUE TO, OR AS A CONSEQUENCE OF involunt intestinal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last obstruction and fistula formation DUE TO, OR AS A CONSEQUENCE OF anorexia bronchial pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1962 thru 1968										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'lly medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Dec. 1962 , to Dec 30, 1968 , that (I) (we) last saw the deceased alive on Dec. 30, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Howard E. Hall			DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 12-30-68				
22d. PHYSICIAN'S NAME (Type) HOWARD E. HALL			M.D. M.D.			22e. ADDRESS Sykesville, Md.				
23a BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 12-2-69			23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery			23d. LOCATION (City or Town) (County) (State) York Pa.	
24. FUNERAL DIRECTOR Harry W. Haight			ADDRESS Sykesville, Md.			25a. REC'D BY REGISTRAR JAN 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

Item #2a File # G408 12 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17358 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 17369											
1. DECEASED NAME (Type or Print) FRANCIS ELMER HARRISON			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 12 Day 19 Year 1968			2b. HOUR M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1877? 1880?		6. AGE (in years last birthday) 91? 88? YRS		7. UNDER 24 HRS MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Month DECEMBER Day 19 Year 1968 2d. HOUR 10:00 AM	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll		
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admiss on) STATE Maryland			13b. COUNTY Baltimore City			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 2005 Dennison St.			14. FATHER'S NAME First John Middle Harrison Last Unk.			15. MOTHER'S MAIDEN NAME First Netti Middle Unk. Last Unk.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk.			16b. SOCIAL SECURITY NO 215-05-5318			17. INFORMANT Records, Springfield State Hospital			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 403X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 146X (b) Nephrosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Fracture, right ankle. Bronchopneumonia.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Fracture, right ankle. Bronchopneumonia.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year 11:40xx 12-1-1968				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) Fell in hallway, Convalescent #1			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Springfield State Hospital, Sykesville, Maryland, Carroll				21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE W. Glenn Speicher				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 12-19-68			
EXAMINER'S NAME (Type) W. Glenn Speicher, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 12-21-68				23c. NAME OF CEMETERY OR CREMATORY Westly Freedom			
24. FUNERAL DIRECTOR Harry W. Haight				ADDRESS Sykesville, Md				25a. REC'D BY REGISTRAR Charles Judge			
								25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 13 Film 408 1-22-69a		MARYLAND STATE DEPARTMENT OF HEALTH	
17359		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
17370		CERTIFICATE OF DEATH	
1 DECEASED-NAME (Type or print)		First Middle Last	
Joseph Henry Heitman			
2a. DATE OF DEATH		2b. HOUR	
December 26, 1968		10:45 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)
Male	White	1-3-97	71 YRS.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH
Florida	U.S.A.		Carroll County, Md.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hospital	Sculptural-Iron worker	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER
General Delivery, U.S.A.	Had no ...		fixed address
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		
First Middle Last	First Middle Last		
unk.	unk.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO	17. INFORMANT Address	
unk.	20-01-4036A	Records, Springfield State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>4124</u> Coronary insufficiency			
DUE TO, OR AS A CONSEQUENCE OF			
(b) <u>Arteriosclerotic cardiovascular disease.</u>			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
CBS, associated with alcohol intoxication with psychotic reaction			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No	City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from <u>10-21</u> , 19 <u>54</u> , to <u>12-26</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-26</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death			
22b. SIGNATURE		22c. DATE SIGNED	
<u>Octavio A. Ruiz</u>		12-27-68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS	
Octavio A. Ruiz, M.D.		Springfield State Hospital	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	1-1-69	Wesley Freedom	Sykesville Md.
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Harry Haight Sykesville, Md.		JAN 3 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 13 Film 407 12-16-68 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17371
1 DECEASED-NAME (Type or print)						2a. DATE OF DEATH				2b. HOUR
Melvin Alverta Hill						Month 12 Day 7 Year 68				215p M
3. SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Female		White		1-13-75		93 YRS.				
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.
Maryland		U.S.A.				Carroll				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Sykesville			Springfield State Hosp			Housewife				
13a. U.S. RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Montez		Carroll		NO		Westminster	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Henry Shipley			Frances Anna Conway							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17 INFORMANT		Address			
No			218-52-3290		Records		Springfield State Hosp. Sykesville Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ironchopneumonia										Days
4127 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4227										Years
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriolosclerotic Cardiovascular disease										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										reaction
Chronic brain syndrome associated with senile brain disease with psychotic										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (th.s hospital) attended the deceased from 9-19-66, 19 to 12-7-68, 19, that (I) (we) lost saw the deceased alive on 12-7-19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					22c. DATE SIGNED					
Dr. Antonius Glahn					12-7-68					
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
Antonius Glahn					Springfield State Hosp. Sykesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		12/10/68		Westminster		Westminster, Md.				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
J. S. Myers Jr. Westminster Md.					DEC 11 1968		J. S. Myers Jr.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/75

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
1 DECEASED NAME (Type or print) Lawrence Leroy Hoffman						2a. DATE OF DEATH Month Dec Day 25 Year 1968			2b. HOUR 1:40 M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH Aug. 30, 1892			6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS 76 DAYS 76		IF UNDER 24 HRS HOURS 76 MIN 76	
7a BIRTHPLACE (State or foreign country) Md.		7b CIT ZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md						
10 CITY OR TOWN OF DEATH Westminster			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Co. Hospt.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Railroad			12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b COUNTY Carroll		13c CITY OR TOWN Hampstead		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Rd 2			
14 FATHER'S NAME First Joseph Middle Hoffman Last Hoffman				15 MOTHER'S M A DEN NAME First Ida Middle Rice Last Rice								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO			16b SOCIAL SECURITY NO 705-10-1921 A		17 INFORMANT Address Mrs. Ella Shamer Rd Finksburg, Md.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Atherosclerotic Heart Disease 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4129 DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200 Uremia												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Dec 25, 1968 , to Dec 25, 1968 , that (I) (we) last saw the deceased alive on Dec 25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death												
22b SIGNATURE John S. Harshey, MD DEGREE MD ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 12/25/68						
22d. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, MD						22e. ADDRESS 8 Anchor St. Westminster, Md.						
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Dec. 28, 1968		23c. NAME OF CEMETERY OR CREMATORY Hampstead, Md.				23d LOCAT ON (City or Town) (County) (State) Hampstead Carroll Co. Md.				
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md. ADDRESS						25a REC'D BY REGISTRAR DEC 30 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR						
Mysses Monroe Holloway						Month 12 Day 7 Year 68			474 M						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
male		negro		1 - 14 - 91			77 YRS.								
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
South Carolina			U.S.A.						Carroll			Md			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY			
Sykesville				Springfield State Hosp.				Barber							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Maryland				Baltimore		Baltimore				1415 Pennsylvania Ave.					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
First Middle Last			First Middle Last												
Riley			Holloway			Agnes Virginia			Ross						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO		17. INFORMANT		Address							
WW 1				WW 1		125 - 01-6853 T		Hospital Records -Springfield St. Hosp.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Cardiac failure												2mons&3wks.			
DUE TO, OR AS A CONSEQUENCE OF															
(b) Multiple bed-sores															
DUE TO, OR AS A CONSEQUENCE OF															
(c) CBS assoc. with cerebral arteriosclerosis															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 9-17, 19 68, to 12-7, 19 68, that (I) (we) last saw the deceased alive on 12-7, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE				22c. DATE SIGNED											
Paul G. Ensor, M.D.				7 Dec 68											
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS											
Paul G. Ensor M.D.				Springfield State Hospital											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				Dec. 14, 1968				St. Mary's Cemetery				BALTIMORE MD.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Frank H. Newell, Ridgely & Son				DEC 20 1968				J. Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) CECELIA			First B. Middle HOOD Last			2a. DATE OF DEATH Month Dec. Day 12 Year 1968			173374 2b. HOUR A 8:30 M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH June 26, 1884			6 AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.						
10. CITY OR TOWN OF DEATH Mt. Airy			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R. D. 2			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY (M.T.S?) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R. D. 2			
14. FATHER'S NAME Henry H. Mullinix			First Middle Last			15. MOTHER'S MAIDEN NAME Mary E. Daley			First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give year or dates of service)			16b. SOCIAL SECURITY NO. 218-52-2485		17. INFORMANT Mrs. Frank Byers			Address Same As #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH about 20 yrs		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4-												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from April, 1951 to Dec, 1968 , that (I) (we) lost saw the deceased alive on Oct. 7 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE W.B. Culwell M.D. DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Dec. 12, 1968				
22d. PHYSICIAN'S NAME (Type) Dr. W. B. Culwell						22e. ADDRESS Mt. Airy, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/14/1968		23c. NAME OF CEMETERY OR CREMATORY Taylorsville		23d. LOCATION (City or Town) (County) (State) Taylorsville, Carroll, Md.						
24. FUNERAL DIRECTOR C. M. Waltz, Box 241, Sykesville, Md.						25a. REC'D BY REGISTRAR DEC 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First LYDIA		Middle (NMN)		Last HOPF		2a. DATE OF DEATH Month DECEMBER 2, 1968		2b. HOUR 5:40 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 5-22-1884		6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll				Md	
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Baltimore City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5615 Laurelton Road		AVE.	
14. FATHER'S NAME First Unknown		Middle Hartman		Last Unknown		15. MOTHER'S MAIDEN NAME First Unknown		Middle Unknown		Last Unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 212-03-8860-D		17. INFORMANT Address Records, Springfield State Hospital							
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 410.9 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery sclerosis</u> 42.1										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CBS associated with senile brain disease, without qualifying phrase											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 7-16-68, 19__, to 12-2-68, 19__, that (I) (we) last saw the deceased alive on 12-2-68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (aid) (did not) view the body after death											
22b. SIGNATURE <u>Isak E. Hapner, M.D.</u>		22c. DATE SIGNED 12-2-68		22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12/4/68		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Woodlawn Balto. Co. Md					
24. FUNERAL DIRECTOR FRAUSE FUNERAL HOME		12163 Charles St.		25a. REC'D BY REGISTRAR DATE DEC 5 1968		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>					

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17205

17376

1. DECEASED-NAME (Type or print) First Middle Last <i>Mazie E. Kexel</i>			2a. DATE OF DEATH Month Day Year <i>December 2 1968</i>		2b. HOUR Min <i>6:01 AM</i>
3. SEX <i>Female</i>	4. RACE <i>Cau.</i>	5. DATE OF BIRTH <i>September 5 1887</i>		6. AGE (In years last birthday) <i>81</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Penna.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i>	
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>84 Uniontown Rd.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <i>Housewife</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Carroll</i>	13c. CITY OR TOWN <i>Westminster</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>84 Uniontown Road</i>
14. FATHER'S NAME First Middle Last <i>Grandville Leese</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Almeda Krumrine</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>NO</i>		16b. SOCIAL SECURITY NO <i>215-20-9677</i>		17. INFORMANT <i>Mrs. Andrew Dietrich</i> Address <i>84 Uniontown Road Westminster Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis, suspected</i> <i>4339</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>3-22 X</i> (b) <i>Generalized Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>acute</i> <i>unknown</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Arteriosclerotic Cardiovascular disease, Gastroenteritis</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>9/30</i> , 19 <i>63</i> , to <i>12-2</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>7-10</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Philip W. Mercer</i> M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>12/2/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Philip W. Mercer</i>		22e. ADDRESS <i>150 W. Main St Westminster Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>December 4, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Shermans Church Cem.</i>	
24. FUNERAL DIRECTOR <i>John E. Gott</i>		ADDRESS <i>329 N. Main St</i>		23d. LOCATION (City or Town) (County) (State) <i>Hanover R.D. 1 Penna.</i>	
25a. REC'D BY REGISTRAR <i>DEC 4 1968</i>		25b. REGISTRAR'S SIGNATURE <i>John E. Gott</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year		2b HOUR	
Bertha Wilmering KUHFUSS						December 30, 1968		6:55PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		2-13-98		70 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Germany		Germany				Carroll County,		Mo	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Sykesville		Springfield State Hospital		Housewife					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Balto. City		Baltimore		YES		600 South Streeper Street	
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Frank Wilmering			Minnie Kuhlmann						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17. INFORMANT		Address			
		215-56-0118		Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). storing the underlying cause last. <u>4201</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Schizophrenic reaction, other and unspecified</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from <u>4-21-1933</u> to <u>12-30-1968</u> , that (I) (we) last saw the deceased alive on <u>12-30-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Francisco J. Ceballos M.D.</u> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <u>12-30-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Francisco J. Ceballos, M.D.</u>						22e. ADDRESS <u>Springfield State Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>Removal</u>		<u>JAN. 9 '69</u>		<u>St. Anthony's</u>		<u>BALTIMORE Md.</u>			
24. FUNERAL DIRECTOR <u>Frank H. Sewell Sr. Pikeville</u>				25a. RECD BY REGISTRAR DATE <u>JAN 13 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Francis Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>George BERNARD Lippy</i>			2a. DATE OF DEATH 12 Month 10 Day 68 Year		2b. HOUR 8 4 M
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>May 2, 1897</i>	6. AGE (in years last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Ind.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Carroll</i>		
10. CITY OR TOWN OF DEATH <i>Monroeville</i>	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Ingrown Nursing Home, Retired Cattle Dealer</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <i>Ind.</i>	13b. COUNTY <i>Carroll Ind.</i>	13c. CITY OR TOWN <i>Westminster</i>	13d. INSIDE CITY LIM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>Rd #1</i>	
14. FATHER'S NAME First Middle Last <i>John Lippy</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Clara Hainley</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) <i>yes WWI</i>		16b. SOCIAL SECURITY NO. <i>218-32-3489</i>	17. INFORMANT Address <i>Elizabeth Lippy wife of Westminster Rd #1, Ind.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma Head Pancreas</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>C Liver metastases jaundice</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>+ Cachexia</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 to 12 yrs</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a. DATE OF OPERATION <i>1/28/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>cholelith cholecystectomy</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>12-30</i> , 1967, to <i>12-10</i> , 1968, that (I) (we) last saw the deceased alive on <i>12-9</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>William Splicher</i>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>12-10-68</i>		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>Westminster Ind.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>12/13/68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Winters Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>New Windsor, Carroll Ind.</i>		
24. FUNERAL DIRECTOR <i>J. E. Myers Jr.</i>	ADDRESS <i>Westminster, Md.</i>		25a. REC'D BY REGISTRAR <i>DEC 13 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 14 & 15 Film 408 1/3/69 kk		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		17379	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
1 DECEASED NAME (Type or Print) Hurley		First FLOYD Middle Floyd Last HURLEY		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month 19 Year 1968	
3 SEX male		4 RACE white		2c. DATE PRONOUNCED DEAD Month December Day 23 Year 1968	
5 DATE OF BIRTH Oct. 29, 1915		6 AGE (in years last birthday) 53 YRS		2d. HOUR M	
7a BIRTHPLACE (State or foreign country) Ohio		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Carroll		10. CITY OR TOWN OF DEATH Westminster		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Co. Gen. Hosp.	
12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) programer		12b KIND OF BUSINESS OR INDUSTRY social security		13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland	
13b COUNTY Carroll		13c CITY OR TOWN Randallstown		13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
13e STREET AND NUMBER 9211 Turnbøll Road		14 FATHER'S NAME First John Middle unknown Last Clarence Lyle		15 MOTHER'S MAIDEN NAME First Ivy Middle Clover Last u/s/own	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) WW1		16b SOCIAL SECURITY NO. 161 18 8291		17. INFORMANT ADDRESS Louise K. Lyle, 9211 Turnbull Rd., 21133	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Injuries					
DUE TO, OR AS A CONSEQUENCE OF 8160					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF					
(c) (c) DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 224					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year UNK P.M. UNK 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Driver of car - went out of control, thrown out of car	
21d INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) street		21f LOCATION Street or R.F.D. No. Carroll, Md.	
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Werner KU Spitz		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 12/24/68	
EXAMINER'S NAME (Type) Werner KU Spitz, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ADDRESS (Street, city, town, or county) Carroll Co; Md.					
23a BURIAL, CREMATION REMOVAL (Specify) burial		23b DATE 12 27 1968		23c NAME OF CEMETERY OR CREMATORY Lakeview Cem.	
24. FUNERAL DIRECTOR Loring Byers		23d LOCATION (City or Town) (County) (State) Liberty Rd. Carroll Co; Md.		25a REC'D BY REGISTRAR DEC 30 1968	
25b REGISTRAR'S SIGNATURE J Charles Judge		25c ADDRESS (Street, city, town, or county) 8728 Liberty Rd; Randallstown, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Nellie R. MANGPT						Dec 26 1968			5:00 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years lost birthday)		7. UNDER 1 YEAR	
female		white		Feb 12 - 1887		87		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Westminster		USA		NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Carroll		Manchester	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	
4129 Victoria		Nursing Home 128 N Main		Housewife		Maryland		Carroll	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
Westminster		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		129 Penna Ave		Charles		Maggie Fable	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
no				Miss Wm J Crabbe 258 Washington Rd Westminster, Md		PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident		2 MONTH	
						4129 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Atherosclerosis		5 YR	
						DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Heart Disease		5 YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
2. 4129									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 7/9, 1962, to 12/26, 1968, that (I) (we) last saw the deceased alive on Dec 20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
W H Foard M.D.		12/26/68		W. H Foard M.D.					
22e. ADDRESS		22f. ADDRESS		22g. ADDRESS					
25 N. Main St		25 N. Main St		25 N. Main St					
Manchester, Md 21102		Manchester, Md 21102		Manchester, Md 21102					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12/28/68		KRIDERS CEMETERY		WESTMINSTER CARROLL, MD			
24. FUNERAL DIRECTOR		24a. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE	
J. S. Myers, Jr.		Westminster, Md.		DEC 30 1968		Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17370

17381

1. DECEASED NAME (Type or print) WILLIAM		First H.	Middle	Last MAY, SR.	2a. DATE OF DEATH Dec Month 30 Day 1968 Year		2b. HOUR 5:40 AM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH Sept. 10, 1904		6. AGE (in years lost, birthday) 64 YRS.		7. UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.		
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Co. Gen. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Bin Operator		12b. KIND OF BUSINESS OR INDUSTRY Quarry		
13a. USUAL RESIDENCE (Where deceased lived, if institut on admission) Maryland STATE		13b. COUNTY Carroll		13c. CITY OR TOWN New Windsor		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route 1
14. FATHER'S NAME John		First W.	Middle	Last May	15. MOTHER'S MAIDEN NAME Grace		First	Middle Bohn Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 215-20-9692		17. INFORMANT Mrs. Melinda R. May		Address Same As #13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4127 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic bronchitis & pulmonary emphysema								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 12/27, 1968 , to 12/30, 1968 , that (I) (we) last saw the deceased alive on 12/30, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE John S. Harshey, M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/30/68		
22d. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY M.D.		22e. ADDRESS 8 Anchor St. Westminster, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/2/1969		23c. NAME OF CEMETERY OR CREMATORY Taylorsville		23d. LOCATION (City or Town) (County) (State) Taylorsville, Carroll, Md.		
24. FUNERAL DIRECTOR C.M. Waltz, Box 241, Sykesville, Md.				25a. REC'D BY REGISTRAR JAN 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION

VR 15-14
3000 FEB 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year			2b. HOUR			
WILLIAM		LEO	McDONALD	12 3 68			5:30 A				
3. SEX	4 RACE		5 DATE OF BIRTH			6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male	Caucasian		08/06-97			71 YRS					
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md		
Dist of Col.		U.S.A.				CARROLL					
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY			
SYKESVILLE		Springfield State Hosp.			Plumber			PLUMBING			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) -STATE-		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Maryland		Montg. Co.		Silver Sp.				9912 Capitol View Ave.			
14. FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last							
Samuel McDonald				Ella Chester							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
No				577-10-6258		Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chorea</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic schizophrenia complicated by</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic plan with cerebral arteriosclerosis with psychotic reaction</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>07/18/68</u> , 19 <u>68</u> , to <u>12/3/68</u> , 19 <u>68</u> , that <u>(I)</u> (we) last saw the deceased alive on <u>12/3/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <u>(I)</u> (we) (did) (do not) view the body after death.											
22b SIGNATURE <u>G. G. Sagisi</u>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 12/3/68				
22d PHYSICIAN'S NAME (Type)					22e ADDRESS						
G. G. Sagisi, M.D.					Springfield State Hospital						
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
BURIAL		12-7-1968		MT. OLIVET CEM		WASHINGTON, D.C.					
24 FUNERAL DIRECTOR					25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE				
W.W. CHAMBERS, INC. SILVER SPRING, MD					DEC 6 1968		<u>William J. Jones</u>				

1. DECEASED NAME (Type or print) Elijah		Middle (NMN) MILLER		2. DATE OF DEATH Month Day Year December 23, 1968		2b HOUR 11:45 P	
3 SEX Male		4 RACE Negro		5. DATE OF BIRTH 3-23-88 ?		6. AGE (In years last birthday) 80? YRS	
7a BIRTHPLACE (State or foreign country) North Carolina		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County, Md.	
10 CITY OR TOWN OF DEATH Sykesville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) laborer		12b KIND OF BUSINESS OR INDUSTRY	
13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b COUNTY Balto. City		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER NO FIXED ADDRESS		14 FATHER'S NAME First Middle Last Wiley Miller		15. MOTHER'S MAIDEN NAME First Middle Last Ellen Edmund			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO 220 24 2232		17 INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 7 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CRS, associated with central nervous system syphilis with psychotic reaction							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from 5-6-, 1963 to 12-23-, 1968 , that (I) (we) last saw the deceased alive on 12-22-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Octavio A. Ruiz, M.D.		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-24-68	
22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.		22e. ADDRESS Springfield State Hospital					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 12-29-68		23c NAME OF CEMETERY OR CREMATORY St. Luke Cemetery		23d LOCATION (City or Town) (County) (State) Sykesville Md.	
24. FUNERAL DIRECTOR Harry W. Haight		ADDRESS Sykesville, Md.		25a. RECD BY REGISTRAR DATE JAN 3 1969		25b REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17373									
17384									
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
Paul Herman Miller					12 24 68			6:00 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 24 HRS	
Male		White		3/16/95		73 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		U.S.A.				Carroll			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Sykesville		Springfield State Hosp.		Office Worker-Crown, Cork & Seal					
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Balt. City		Balt. City				303 Whitridge Avenue	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
William Miller William Miller				Margaret Krause Margaret Krause					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT (Hospital Records) Mrs. Beatrice B. Miller					
No		212-09-8166							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure								2 days	
7517 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 354X								(b) DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
C.B.S. Associated with cerebral arteriosclerosis with psychotic reaction.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (he/she) attended the deceased from 1/31, 1965, to 12/24, 1968, that (he/she) lost saw the deceased alive on 12/24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (he/she) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				22c. DATE SIGNED					
				12/24/68					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
ISAK, E. HARPER				Springfield State Hosp. Sykesville, MD					
23a. BURIAL, CREMATION, REMOVA (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12/27/68		Loudon Park		Baltimore Md.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.				DEC 26 1968					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

17374

17385

1. DECEASED NAME (Type or print) First Middle Last L L L BERTHA MOHL HENRICH			2a. DATE OF DEATH Month Day Year Dec 29 1968			2b. HOUR 10:25 AM							
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 3-2-1880		6. AGE (In years last birthday) 88 YRS		7. NUMBER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md.							
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL CO. GEN. HOSP.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWORK			12b. KIND OF BUSINESS OR INDUSTRY HOME				
13a. U.S. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY CARROLL		13c. CITY OR TOWN SYKESTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER None					
14. FATHER'S NAME First Middle Last HENRY MOHL HENRICH			15. MOTHER'S MAIDEN NAME First Middle Last AMELIA WERNER										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO None		17. INFORMANT HOSPITAL RECORDS		Address							
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 4127 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4127 Central vascular insufficiency												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 12/11, 1968, to 12/29, 1968, that (I) (we) lost saw the deceased alive on 12/29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE John S. Harshey, M.D.				22c. DATE SIGNED 12/29/68		22d. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
CREMATION		12-31-68		J. W. LEE'S SONS		WASH D.C.							
24. FUNERAL DIRECTOR Arthur A. Haight				ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR JAN 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17385

17386

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, and any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1 DECEASED NAME (Type or Print) JIMMY CARSON MOORE			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> EST. <input type="checkbox"/> 12-24-1968			2b HOUR 5:30 A.M.		
3 SEX Male	4 RACE Colored	5 DATE OF BIRTH 11-27-46	6 AGE (In years last birthday) 22 YRS	7 UNDER 1 YEAR MONTHS 0 DAYS 0	7 UNDER 24 HRS HOURS 0 MIN 0	2c DATE PRONOUNCED DEAD Month 12 Day 24 Year 1968		
7a BIRTHPLACE (State or foreign country) N.C.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Carroll			10 Md	
10 CITY OR TOWN OF DEATH Henryton			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.)		
13a U.S.A. RESIDENCE (Where deceased lived, if institution) STATE Md.			13b COUNTY Baltimore			13c STREET AND NUMBER 941 Ashburton St.		
14 FATHER'S NAME Arthur TOWNS			15 MOTHER'S MAIDEN NAME JONIE TOWNS			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)		
16b SOCIAL SECURITY NO			17 INFORMANT Juliette Moore			ADDRESS same		
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO, OR AS A CONSEQUENCE OF choking Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) choking DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 823.4								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year 5:30 PM 12-24-68			21c HOW INJURY OCCURRED (Interpreture of injury in Part 1 or Part 2 Item 18) Ran off Road + into Pond of water		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Hospital Grounds			21f LOCATION Street or R.D. No. Henryton Rd City or Town Henryton County Carroll State Md		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE W. Lewis Speicher M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 12-24-68		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS 135 E. Main St. Westminster Carroll Md		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 12-29-68			23c NAME OF CEMETERY OR CREMATORY Arbutus Mem. Ch.		
24 FUNERAL DIRECTOR Wilmington P. Phillips			ADDRESS 1727 N. Meade St			25a REC'D BY REGISTRAR Charles Judge		
						25b REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1-68

17386

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17387

1 DECEASED NAME (Type or print) First Middle Last NORA Virginia MUMAW			2a. DATE OF DEATH Month Day Year 12 25 1968			2b. HOUR 8:30 A M					
3 SEX FEMALE		4. RACE WHITE		5 DATE OF BIRTH 11-22-95		6 AGE (In years last birthday) 73 YRS		IF UNDER YEAR MONTHS DAYS 1 3		IF UNDER 24 HRS. HOURS MIN 1 3	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL			Md.		
10. CITY OR TOWN OF DEATH SYKESTVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRINGFIELD STATE HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) BEAUTICIAN			12b. KIND OF BUSINESS OR INDUSTRY Retired				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3513 BAYVIEW RD Kensington Md			
14 FATHER'S NAME First Middle Last LEMOUEL RYMAN			15 MOTHER'S MAIDEN NAME First Middle Last SARAH ESTEP								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, or (if unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 578-464525		17. INFORMANT Address SPRINGFIELD STATE HOSP SYKESTVILLE MD						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia TOOK DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 491x											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 11-27, 1968 , to 12-25, 1968 , that (I) (we) last saw the deceased alive on 12-25-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jose Chappelle		DEGREE MD		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-25-68					
22d. PHYSICIAN'S NAME (Type) Jose Chappelle		22e. ADDRESS Springfield State Hospital									
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 12-27-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Suitland Prince Georges Co. Md.					
24. FUNERAL DIRECTOR Pumphrey		ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR JAN 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17388

1. DECEASED NAME (Type or print) RUSSELL LEON MUMMAUGH			2a. DATE OF DEATH Month Dec Day 26 Year 1968		2b. HOUR 7:45 M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH JULY 17 1916		6. AGE (In years last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH CARROLL CO.		
10. CITY OR TOWN OF DEATH WESTMINSTER	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL CO. GEN. HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LARDER		12b. KIND OF BUSINESS OR INDUSTRY —
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY CARROLL	13c. CITY OR TOWN WESTMINSTER	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RD #4	
14. FATHER'S NAME First Middle Last EARL W. MUMMAUGH		15. MOTHER'S MAIDEN NAME First Middle Last MINNIE BELL ARBAUGH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. ?		17. INFORMANT Address MRS. MILDRED R. NULL WESTMINSTER, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John S. Harshey, MD		22c. DATE SIGNED 12/26/68		22d. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, MD	
22e. ADDRESS 8 Archer St. Westminster, Md		23a. REC'D BY REGISTRAR DATE DEC 30 1968			
23b. REGISTRAR'S SIGNATURE Charles Judge		23c. NAME OF CEMETERY OR CREMATORY BETHEL CEMETERY			
23d. LOCATION (City or Town) (County) (State) FINNSBURG, AD (CARROLL MD)		23e. ADDRESS J. S. Myers, Jr. Westminster, Md			
23f. BURIAL, CREMATION, REMOVA, (Specify) BURIAL		23g. DATE 12/29/68		23h. NAME OF CEMETERY OR CREMATORY BETHEL CEMETERY	
23i. LOCATION (City or Town) (County) (State) FINNSBURG, AD (CARROLL MD)		23j. ADDRESS J. S. Myers, Jr. Westminster, Md			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17389

1. DECEASED-NAME (Type or print) Elmer		First		Middle		Last		2a. DATE OF DEATH Month 12 Day 27 Year 68			2b. HOUR 8:55 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 9-7-00				6. AGE (In years lost birthday) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) New Jersey		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County, Md.						
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Loan company mgr.				12b. KIND OF BUSINESS OR INDUSTRY Loan Co.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 261 North Centre Street				
14. FATHER'S NAME Israel		First		Middle		Last		15. MOTHER'S MAIDEN NAME Matilda		First Carlson Middle XXXXXXXXXX Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 214-05-4085		17. INFORMANT Springfield State Hospital records						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks		
4121 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost Arteriosclerotic heart disease.										years		
DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary										years		
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis. emphysema.										years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (psychotic reaction) Chronic brain syndrome associated with cerebral arteriosclerosis, with/												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FIN CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY; OFFICE, BUILDING, ETC)		21f. LOCATION Street or RFD No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 11-8 , 19 67 , to 12-27 , 19 68 , that (I) (we) last saw the deceased alive on 12-27-68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>M. Sucholeiki</i>		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-27-68						
22d. PHYSICIAN'S NAME (Type) M. Sucholeiki, M.D.		22e. ADDRESS Springfield State Hospital Sykesville, Maryland										
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 12-30-68		23c. NAME OF CEMETERY OR CREMATORY Lombardy Cem.		23d. LOCATION (City or Town) Wilmington, N. C., Delaware		(County) (State)				
24. FUNERAL DIRECTOR Harry W. Haight		SYKESVILLE, MD.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE DEC 31 1968				

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #1, Film 3409 1/31/49 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Item #14, Film 3409 1/31/49													
1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year		2b. HOUR M	
ELBERT		COY		REITZEL		JR		12-6-		1968		1:15 P	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	7. UNDER 1 YEAR	8. UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR		M	
Male	White	6-12-26		42 YRS	MONTHS	DAYS		Month 12 Day 6 Year 1968		1:15 P		M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH					
Maryland		U.S.A.		WIDOWED		DIVORCED		Carroll					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY							
Sykesville		Springfield State Hospital		Newspaper copy boy		Newspaper							
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Maryland		Howard		Simpsonville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		--					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle	
Elbert		COY		REITZEL		SR		Myrtle		PLITT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS							
No		2		Springfield Hospital		Sykesville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia										minutes			
411X DUE TO, OR AS A CONSEQUENCE OF													
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. 757													
(b) occlusion of larynx by meat										minutes			
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
Schizophrenic reaction, chronic undifferentiated type													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
		11:4 PM 2-6 1968		-- While eating lunch									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or RFD No		City or Town		County		State			
		E. Ward		Springfield		Sykesville		Carroll		Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
ACTUAL SIGNATURE		EXAMINER'S NAME (Type) W. Glenn		SPEICHER		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED	
												12-6-68	
23a. BURIAL CREMATION, APPROVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		County		State			
Burial		12-9-68		Woodlawn		Woodlawn		Baltimore		Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Higdon & Son - Slack		Ellicott City Md.		DATE DEC 10 1968		J. Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

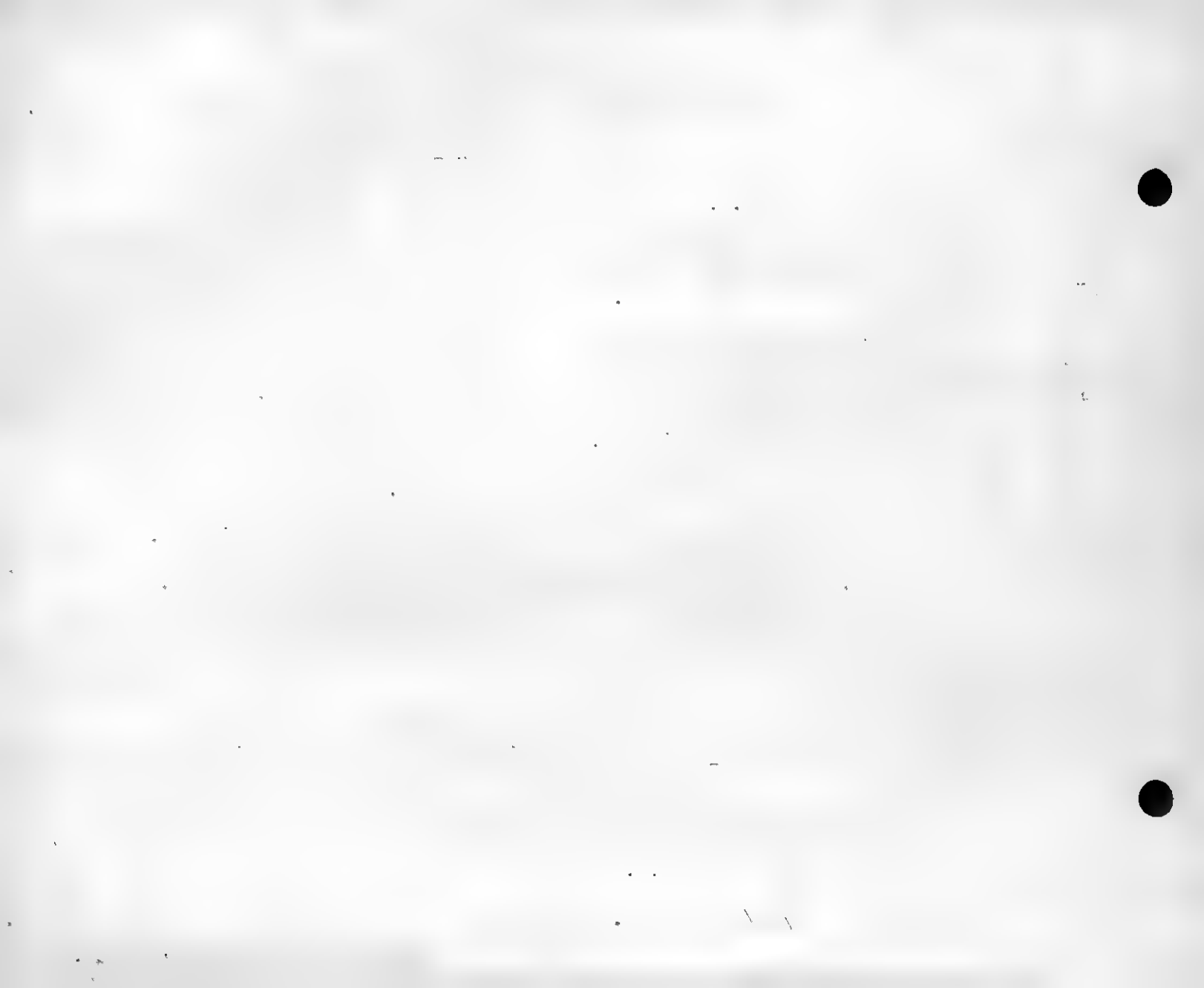
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17380					17391				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH				
First		Middle		Last		Month		Day	
CLINTON		JOHN		ROCHE		DECEMBER		19	
				SR.		1968			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR	
Male		White		7-31-17		51 YRS		MONTHS DAYS	
7b. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland		U.S.A.				Carroll		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Sykesville		Springfield State Hospital		Heating & Plumbing Maintenance Worker - self-employed					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission, STATE)		13b. COUNTY		13c. CITY OR TOWN		13d. INS. OF CITY, J.M.T.P.		13e. STREET AND NUMBER	
Maryland		Baltimore City		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2606 Evergreen Ave.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
Henry J. Roche		Elizabeth Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Yes		218-07-2600		Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Failure</u>									
DUE TO OR AS A CONSEQUENCE OF (b) <u>Recent myocardial infarction</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary arteriosclerosis</u>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
<u>4109</u> <u>days</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No		City or Town	
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from <u>4-25-66</u> , 19 <u>66</u> , to <u>12-19-68</u> , 19 <u>68</u> , that (I) (we) lost									
saw the deceased alive on <u>12-19-68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the									
causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
<u>Octavio A. Ruiz M.D.</u>								12-19-68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Octavio A. Ruiz, M. D.		Springfield State Hospital							
		Sykesville, Maryland 21784							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		12/23/68		Balto. Nat. Cem.		Baltimore, Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Schimmek Funeral Home, 3331 Brehms Lane		DATE		DEC 24 1968					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The deceased remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Lloyd Raphael SANDERS						2a. DATE OF DEATH Month December Day 14 Year 1968			2b. HOUR 9 a. M		
3. SEX male		4. RACE white		5. DATE OF BIRTH 10-6-1904		6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll			Md		
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Machine Operator			12b. KIND OF BUSINESS OR INDUSTRY Lanids Machine Co				
13a. USUAL RESIDENCE (Where deceased lived, if institut an Residence before adm'ssion) STATE Maryland		13b. COUNTY Washington Co.		13c. CITY OR TOWN Highfield		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 16			
14. FATHER'S NAME First Harry L. Middle Sanders				15. MOTHER'S MAIDEN NAME First Catherine Middle Sanders Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO 162-09-7371		17. INFORMANT Address Springfield State Hosp. Records							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia. 4129 DUE TO, OR AS A CONSEQUENCE OF (b) Multiple infected bed sores. DUE TO, OR AS A CONSEQUENCE OF (c) Severe arteriosclerotic cardio-vascular disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4129										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks weeks years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus. CBS assoc. with cerebral arteriosclerosis with behavioral reaction.											
19a. DATE OF OPERATION		19b. CONDIT.ON FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCAT ON Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 6-20-68 , 19____, to 12-14-68 , 19____, that (A) (we) lost saw the deceased alive on 12-14-68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE Dr. Antonius Glahn DEGREE				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-14-68					
22d. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.				22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/17/1968		23c. NAME OF CEMETERY OR CREMATORY St. Mary Cemetery		23d. LOCATION (City or Town) (County) (State) Fairfield Adams Penna.					
24. FUNERAL DIRECTOR Samuel Y. Love				ADDRESS Wilmington, Pa		25a. REC'D BY REGISTRAR DATE DEC 18 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print) <i>Walter John Schick</i>						2a. DATE OF DEATH Month <i>December</i> Day <i>28</i> Year <i>1968</i>			2b. HOUR <i>9:15</i> AM			
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>May 26 1893</i>			6 AGE (In years last birthday) <i>75</i> YRS.		7 UNDER 1 YEAR MONTHS		8 UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <i>Indiana</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <i>Carroll</i> Md.					
10 CITY OR TOWN OF DEATH <i>Manchester</i>				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>125 N. Main Street</i>				12a USUAL OCCUPATION (Kind of work done or most of working life, even if retired) <i>Government Employee</i>			12b KIND OF BUSINESS OR INDUSTRY <i>U.S. Navy</i>	
13a USUAL RESIDENCE (Where deceased lived, if in institution) <i>Maryland</i>				13b. COUNTY <i>Carroll</i>		13c CITY OR TOWN <i>Hampstead</i>		13d INS. OF CITY - M.D.S.P. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>111 Summit Ave</i>		
14 FATHER'S NAME First <i>Unknown</i> Middle <i>Unknown</i> Last <i>Unknown</i>						15. MOTHER'S MAIDEN NAME First <i>Unknown</i> Middle <i>Unknown</i> Last <i>Unknown</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no</i>				16b SOCIAL SECURITY NO. <i>218-26-0415 A</i>		17. INFORMANT <i>Lobam Schick</i>			Address <i>Hampstead Md</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>7129</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i></i>												
19a. DATE OF OPERATION <i></i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i></i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR AM <i></i> Month <i></i> Day <i></i> Year <i>19</i> P.M. <i></i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i></i>						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i></i>			21f. LOCATION Street or R.F.D. No <i></i> City or Town <i></i> County <i></i> State <i></i>						
22a. I certify that (I) (this hospital) attended the deceased from <i>1-28-68</i> , 19 <i>68</i> , to <i>12-28</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>12-27-68</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Joseph E. Bush MD</i>						DEGREE <i>MD</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>12-28-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>Joseph E. Bush MD</i>						22e. ADDRESS <i>Hampstead Maryland</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>Dec. 31, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Grace Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Upperco, Md.</i>				
24. FUNERAL DIRECTOR ADDRESS <i>Tipton - Eline Funeral Home Hampstead, Md.</i>						25a. REC'D BY REGISTRAR DATE <i>DEC 31 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last Catherine - Simpson					2a. DATE OF DEATH 12 Month 26 Day 68 Year			2b. HOUR 5:20 PM		
3 SEX female		4 RACE white		5. DATE OF BIRTH 10/9/1890			6. AGE (In years last birthday) 78 YRS.			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.				
10. CITY OR TOWN OF DEATH Rural--Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) teacher		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 416 N. Broadway	
14. FATHER'S NAME First Middle Last Francis M. Simpson					15. MOTHER'S MAIDEN NAME First Middle Last Mary - McTaggart					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no			16b. SOCIAL SECURITY NO. 220-54-6623		17. INFORMANT Address Springfield Hospital records, Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, left lower lobe DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 490x										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Schizophrenic reaction, other and unspecified.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1/24/1934 , to 12/26/1968 , that (we) last saw the deceased alive on 12/26/1968 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did not) view the body after death.										
22b. SIGNATURE B. Lleras, M.D.					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/26/68			
22d. PHYSICIAN'S NAME (Type) R. Lleras, M.D.					22e. ADDRESS Springfield State Hospital Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/30/68		23c. NAME OF CEMETERY OR CREMATORY Loudon Park			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Leonard J Ruck Inc Baltimore, Maryland					25a. REC'D BY REGISTRAR DEC 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First <i>Margaret</i> Middle <i>Jane</i> Last <i>Sisson</i>			2a. DATE OF DEATH Month <i>12</i> Day <i>5</i> Year <i>68</i>			2b. HOUR <i>9⁰⁷</i> M			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>May 2, 1884</i>		6. AGE (In years last birthday) <i>84</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i>		Md	
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Carroll County General</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Upperco</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Old Hanover Road</i>	
14. FATHER'S NAME First <i>William</i> Middle <i>C.</i> Last <i>Cooper</i>			15. MOTHER'S M.A.DEN NAME First <i>Virginia</i> Middle <i>Shachelford</i> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO <i>213-10-0588</i>		17. INFORMANT <i>Mr. Frazier F. Sisson</i>		Address <i>Upperco, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>CEREBRAL HEMORRHAGE</i>									<i>33 HOURS</i>
4120 DUE TO, OR AS A CONSEQUENCE OF (b) <i>HYPERTENSIVE CARDIOVASCULAR DISEASE</i>									<i>YEARS</i>
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
4									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>12/4</i> , 19 <i>68</i> , to <i>12/5</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12/5</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Vincent J. Frazier</i>					22c. DATE SIGNED <i>12/5/68</i>		22d. PHYSICIAN'S NAME (Type)		
22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>12/9/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Evergreen Memorial</i>		23d. LOCATION (City or Town) <i>Finksburg, Md.</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>J. F. Eline & Sons Reisterstown, Md.</i>					25a. REC'D BY REGISTRAR <i>DEC 9 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A 5/14/81
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17385

17386

1. DECEASED-NAME (Type or Print) CATHERINE BESSIE SOCKS			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI <input type="checkbox"/> MATED <input type="checkbox"/> 12-9 19 68			2b. HOUR 7 M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH 8-18-17	6. AGE (in years last birthday) 51 YRS	7. INDEX YEAR MONTHS 12 DAY 9	8. IF UNDER 24 HRS HOURS 4 MIN 50	2c. DATE PRONOUNCED DEAD Month 12 Day 9 Year 1968	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll	
10. CITY OR TOWN OF DEATH Spikesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Domestic		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME First Leonard Middle M. Last Stevens		15. MOTHER'S MAIDEN NAME First Nettie Middle Dennis		13e. STREET AND NUMBER 47 High St.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. Unk.		17. INFORMANT Records, Springfield State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary embolism 450x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 465x							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W. Glenn Speicher, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 12-9-68	
EXAMINER'S NAME (Type) W. Glenn Speicher, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 130 S. Church St. Westminster, Md.			
23a. BURIAL, CREMATION, Burial		23b. DATE Dec. 12, 68		23c. NAME OF CEMETERY OR CREMATORY St. Paul		23d. LOCATION (City or Town) (County) Clear Spring, Wash. Md.	
24. FUNERAL DIRECTOR Thompson Funeral Home				25a. REC'D BY REG. STRAR DEC 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



17386

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17397

1. DECEASED NAME (Type or print) <u>Uddie Pearl Tipton</u>			2a. DATE OF DEATH Month <u>December</u> Day <u>9</u> Year <u>1968</u>			2b. HOUR <u>5A</u> M	
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>August 26 1892</u>		6. AGE (In years last birthday) <u>76</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Carroll</u>	
10. CITY OR TOWN OF DEATH <u>Hampstead</u>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>317 N. MAIN STREET</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <u>MARYLAND</u>		13b. COUNTY <u>Carroll</u>		13c. CITY OR TOWN <u>HAMPSTEAD</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>317 N. MAIN</u>		14. FATHER'S NAME First <u>THOMAS</u> Middle <u>NAYLOR</u> Last <u>IDA</u>		15. MOTHER'S MAIDEN NAME First <u>M.</u> Middle <u>Myers</u> Last <u>Myers</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>NO</u>		16b. SOCIAL SECURITY NO. <u>214-34-4753</u>		17. INFORMANT <u>Mrs. MARIE GILL</u>		Address <u>HAMPSTEAD MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u>							
41 <u>?</u> DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>Arteriosclerotic Cardiovascular Disease</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4221</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from <u>March 2, 1958</u> to <u>December 9, 1968</u> , that (I) (we) last saw the deceased alive on <u>December 8, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Joseph E. Bush MD</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>12-9-68</u>	
22d. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				22e. ADDRESS <u>HAMPSTEAD MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 11, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hampstead Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hampstead Carroll Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Tipton - Eline Funeral Home Hampstead, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 11 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

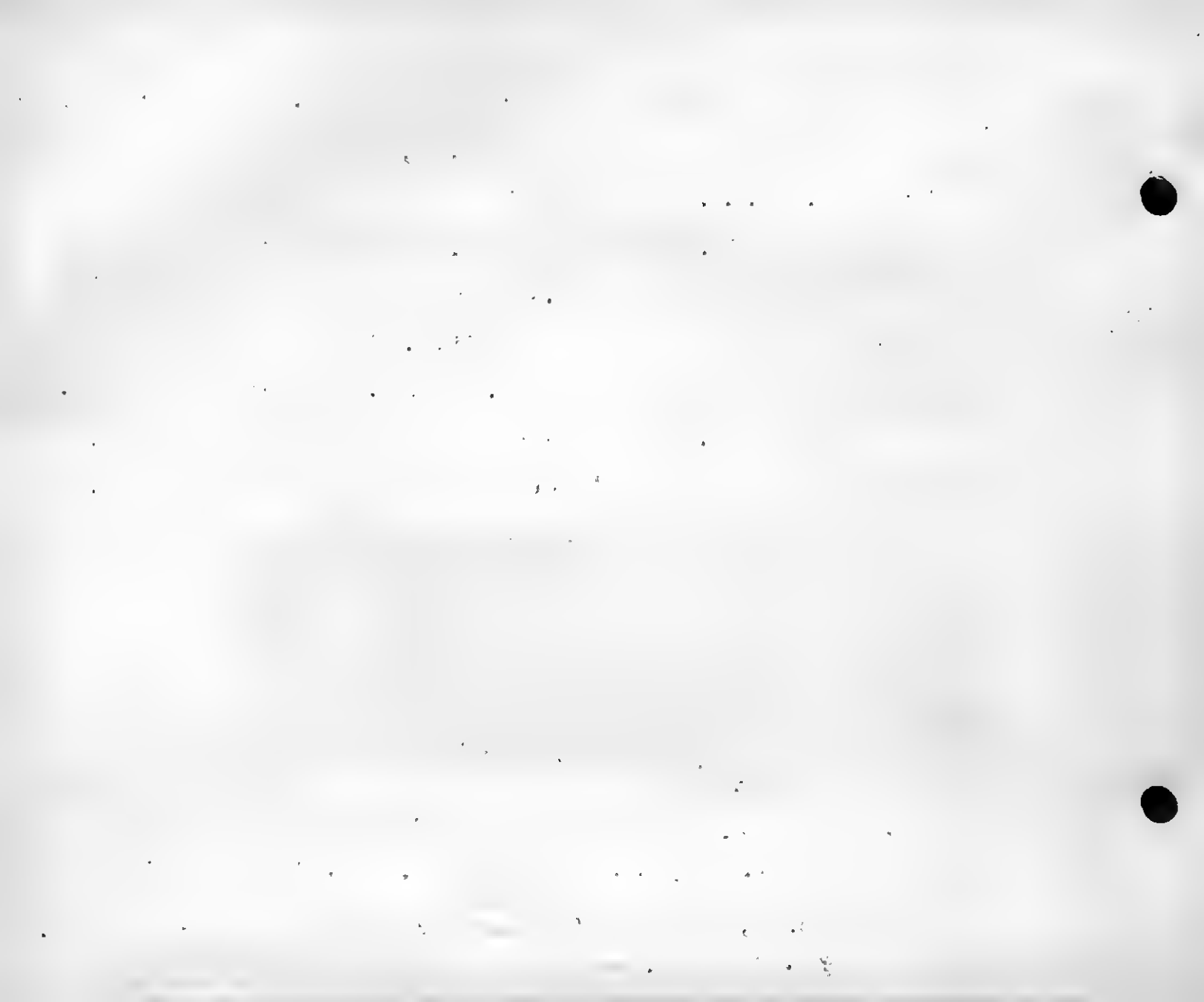
17387										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17398			
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR			
Raymond Dikeman Tyrrell										Month 12 Day 19 Year 68										9 15 M			
3 SEX Male			4. RACE White			5. DATE OF BIRTH May 17, 1893			6 AGE (In years last birthday) 75 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.								
7a. BIRTHPLACE (State or foreign country) Conn.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll Co. Md.														
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Co. Gen. Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Truck Driver			12b. KIND OF BUSINESS OR INDUSTRY Trucking														
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Owings Mills			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 107 Tollgate Rd.											
14. FATHER'S NAME First Middle Last Dwight Tyrrell			15. MOTHER'S MAIDEN NAME First Middle Last Annie Daniels Dikeman																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO (If yes give war or dates of service) 216-01-7930			17 INFORMANT Mrs. Audrey Houseknecht			Address 123 Tollgate Rd. Owings Mills.														
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC LYMPHOCYTIC LEUKEMIA</u> 2041 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>2040</u> (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>VIRAL UPPER RESPIRATORY INFECTION</u>																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/7</u> , 1968, to <u>12/19</u> , 1968, that (I) (we) last saw the deceased alive on <u>12/19</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <u>Frederick J. Krowczynski MD</u>														22c. DATE SIGNED <u>12/19/68</u>									
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Dec. 21, 1968			23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland														
24. FUNERAL DIRECTOR <u>H. J. Echhardt</u>						ADDRESS Owings Mills, Md.			25a. RECD BY REGISTRAR DATE DEC 23 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 15-1
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
17388 CERTIFICATE OF DEATH 17399											
1. DECEASED-NAME (Type or print) Georgia First E. Middle Ward Last						2a. DATE OF DEATH Dec. Month 20 Day 68 Year			2b. HOUR 10:30 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH Aug. 21, 1895			6. AGE (In years last birthday) 73 YRS		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Fairmount Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County Md.					
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. 244 Mineral Hill Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) house wife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Oakland Road		
14. FATHER'S NAME First George Middle Ford Last				15. MOTHER'S MAIDEN NAME First Amelia J. Middle Dize Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. NO		17. INFORMANT Address Mr. Walter E. Ward 3416 Parkington Ave. 15					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Thrombosis, acute DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac arrest. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Dec. 1 thru Dec. 20	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 12/11											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Dec. 1, 1968 , to Dec. 20, 1968 , that (I) (we) last saw the deceased alive on Dec. 20, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Howard E. Hall DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/20/68			
22d. PHYSICIAN'S NAME (Type) Howard E. Hall, M.D.						22e. ADDRESS College Ave., Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 23, 68		23c. NAME OF CEMETERY OR CREMATORY Lakesview Memorial Park			23d. LOCATION (City or Town) Liberty Road (County) Baltimore Co. (State)				
24. FUNERAL DIRECTOR ADDRESS Loring Myers 8728 Liberty Rd. Randallstown						25a. RECD BY REGISTRAR DEC 24 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/66

17380

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17400

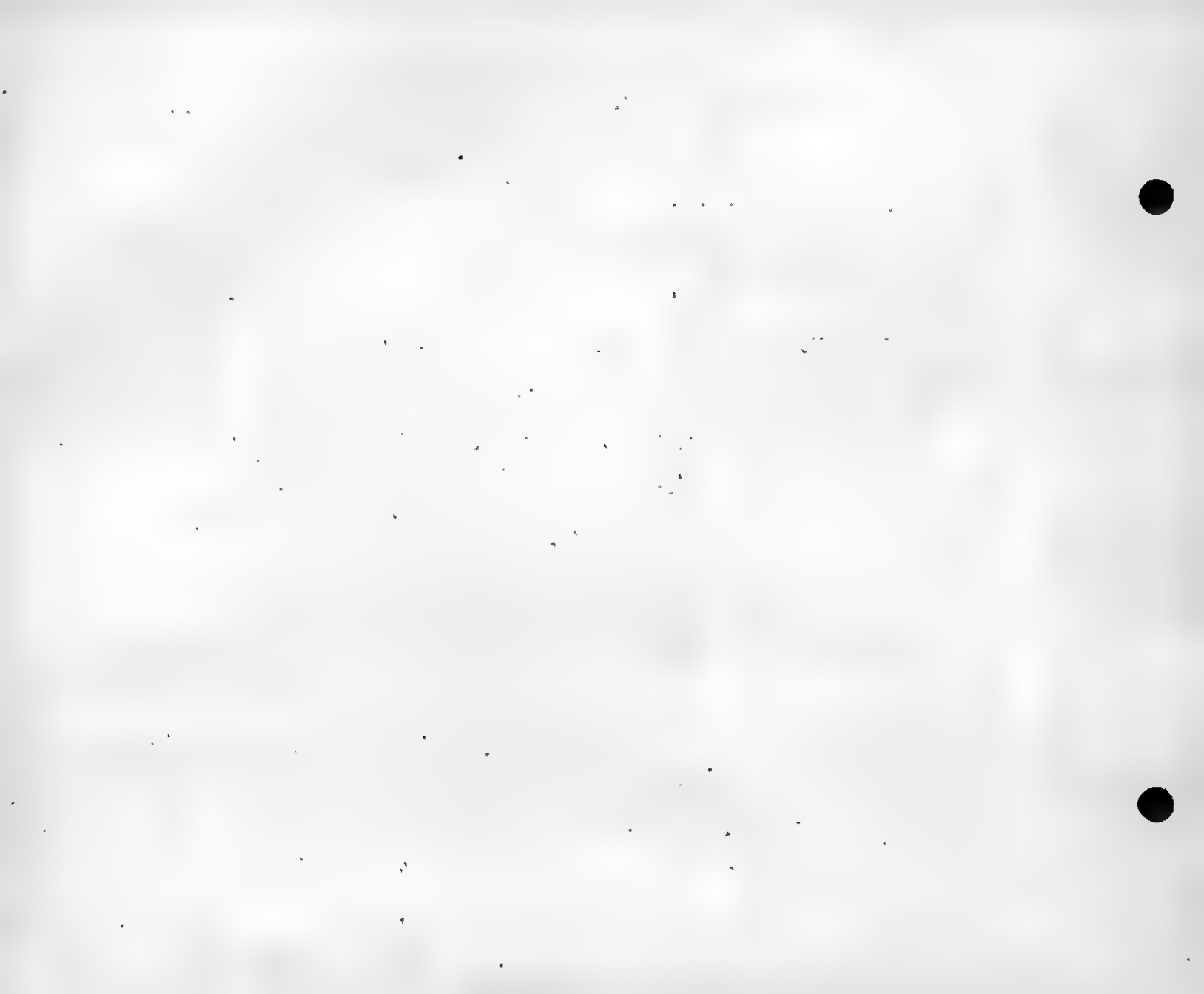
1. DECEASED NAME (Type or print)		First LEE	Middle JESSE	Last WILDER	2a. DATE OF DEATH Month 12 Day 10 Year 68			2b. HOUR 3:45 A	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 09/15/89		6. AGE (in years last birthday) 79 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Tennessee		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Gaither		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Cuthbert Rd.	
14. FATHER'S NAME First Middle Last William Wildey		15. MOTHER'S MAIDEN NAME First Middle Last Minerva Lamb							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO 215-18-0363		17. INFORMANT Address Springfield State Hosp. Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>bronchopneumoniz, bilateral</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>heart failure due to old myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4201</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days mths or yr.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CPS assoc with cerebral arteriosclerosis with psychotic reaction</u> <u>Chronic pulmonary dysfunction of psychotic disorder</u>									
19a. DATE OF OPERATION <u>12/10/68</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>12/10/68</u>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/15/53</u> , 19 <u>68</u> , to <u>12/10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/10/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Charles G. Sagisi</u>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/10/68			
22d. PHYSICIAN'S NAME (Type) G. G. Sagisi				22e. ADDRESS Springfield State Hospital, Sykesv., Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-12-68		23c. NAME OF CEMETERY OR CREMATORY Lutheran Burial		23d. LOCATION (City or Town) (County) (State) Sykesville Md			
24. FUNERAL DIRECTOR Harry W. Wright				ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR DATE DEC 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MIDDLE											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
WILLARD			F. WILSON			Dec. 24, 1968			9:20 A.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN.
Male		White		Nov. 23, 1882			86 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md	
Maryland		U.S.A.					Carroll				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Gist			Ross Nursing Home			Farmer-retired					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIM-157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Carroll			Sykesville				R. D. 3	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Greenbury			WILSON			Frances O.			Shipley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT Address					
No			None			Mrs. Elva M. Wilson			Same As #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>ASHD, Arteriosclerosis Gen.</u>										1968	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Central Arteriosclerosis, Chronic</u>										+c	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Brain Syndrome - Cardiac Arrest</u>										12-24-68	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>60</u> , to <u>12-24</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED								
Howard E. Hall			12-24-68								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
Howard E. Hall			Sykesville, Md								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			12/27/1968			Lakeview Memorial Gardens			Carroll Co., Md.		
24. FUNERAL DIRECTOR ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
C.M. Waltz, Box 241, Sykesville, Md.			DEC 30 1968			Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Rose Rosine WINSHIP						Dec Month 21 Day 1968 Year		2:25A M		
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
F		W		July 28, 1874		94 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S. A.				Carroll Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Sykesville 21784		Grand View Mansion		HW		own home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland				Baltimore				3641 Greenmount Avenue		
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last	
Christian Simond						Mary Bechkel				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give year or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address		
no				215-48-4669		Edward J. Winship		(Same)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular disease</u> 30 yrs										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>Arteriosclerotic Heart Disease</u> 30+yrs										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>General Arteriosclerosis</u> 30+yrs.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
4 <u>Advanced general senile changes</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from <u>3/15/64</u> , 19 <u> </u> , to <u>12/21/68</u> , 19 <u> </u> , that <u>(I)</u> (we) last saw the deceased alive on <u>12/21/68</u> , 19 <u> </u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(I)</u> (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED		22d. ADDRESS						
<u>Wm. H. Lawson, Jr., M.D.</u>		12/21/68		Box 54, RD #2, Sykesville, Maryland 21784						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. ADDRESS						
Wm. H. Lawson, Jr., M.D.										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		12/23/68		Druid Ridge		Pikesville, Balto. Co.				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		Md.				
H.W. Jenkins & Sons Co.		4905 York Rd.		DEC 24 1968		<u>Charles Judge</u>				
BALTO. 12, Md.										

(27)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

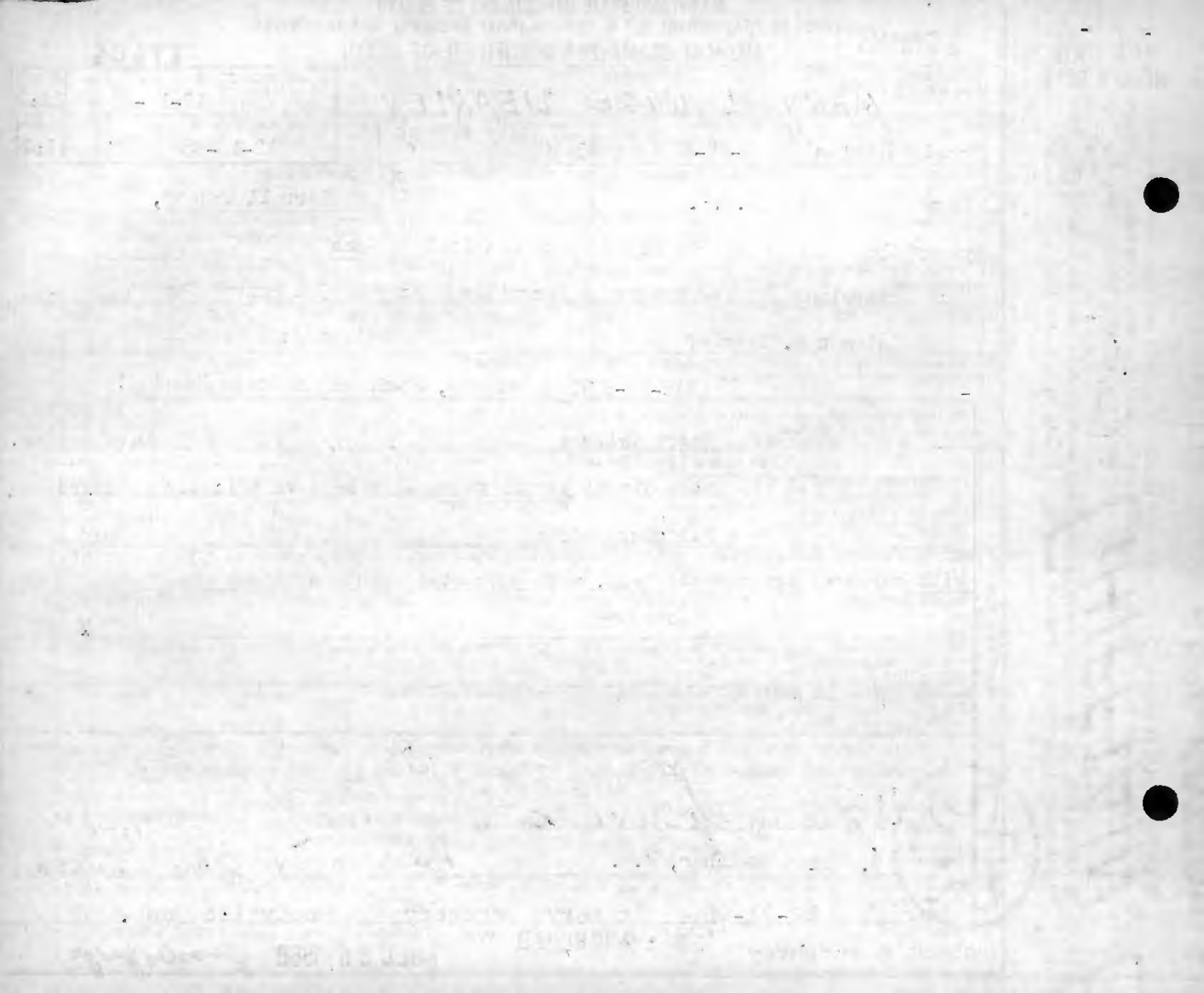
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17302		17403						17403	
1. DECEASED-NAME (Type or print) Margaret Antionette Wynn					2a. DATE OF DEATH December 22, 1968			2b. HOUR 11:20a	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 5-12-94		6. AGE (in years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b. CITY OR TOWN Balt. City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3 25 Birkwood Place	
14. FATHER'S NAME First Middle Last Joseph V anbuskirk			15. MOTHER'S MAIDEN NAME First Middle Last Unknown Anna ?????						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 207-01-6398D		17. INFORMANT Records Springfield State Hospital Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Influenza</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4/10X</u> (b) <u>Diabetes Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic brain</u> <u>Syndrome assoc. with senile brain disease with psychotic reaction</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>9-5-</u> , 19 <u>68</u> , to <u>12-22-</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-22-</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Renato N. Espina, M.D.</u>				22c. DATE SIGNED <u>12/22/68</u>					
22d. PHYSICIAN'S NAME (Type) Renato N. Espina, M. D.				22e. ADDRESS Springfield State Hospital Sykesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>12-26-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		23d. LOCATION (City or Town) <u>Scranton</u>		(County) (State) <u>PA</u>	
24. FUNERAL DIRECTOR <u>Frank H. Seitz</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 27 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year		2b. HOUR		
MARY LOUISE YEARLEY						OF ESTI- DEATH MATED <input type="checkbox"/> 12-18-68 19		11:20		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR		
Female	White	4-28-85	83 YRS			12-18-68 19		11:20		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Iowa		U.S.A.				Carroll County, Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield State Hospital			None				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Montgomery		Rockville		YES		701 Monroe Street	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Solomon E. Yearley			Melissa Jane Samuels							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
			215-48-3075		Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u>									Days or Wks.	
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>Stenosis of aortic valve with left ventricular hypertrophy</u>									Years	
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>Pulmonary edema</u>									Day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CBS associated with cerebral arteriosclerosis, with psychotic reaction										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED				
EXAMINER'S NAME (Type) W. Glenn Speicher, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			12-19-68				
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			12-19-68				
			ADDRESS (City or town, or county)			Carroll County, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)				
Burial		12-21-68		St Marys Cemetery		Rockville Mont. Md				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Robert A Pumphrey			Bethesda, Md			J Charles Judge				



17394

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17405

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or Print) First <u>JOHN</u> Middle <u>LUTHER</u> Last <u>ZEPP</u>			2a. DATE KNOWN OF DEATH Month <u>12</u> Day <u>26</u> Year <u>1968</u>			2b. HOUR <u>4A.M</u>					
3. SEX <u>MALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH <u>JULY 1910</u>		6. AGE (In years last birthday) <u>58</u> YRS.		7c. DATE PRONOUNCED DEAD Month <u>12</u> Day <u>26</u> Year <u>1968</u>			
7a. BIRTHPLACE (State or foreign country) <u>CARROLL CO. MD.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>CARROLL CO.</u>			Md.		
10. CITY OR TOWN OF DEATH <u>WESTMINSTER</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>54 JOHN ST.</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>LABORER</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>LUMBER YARD</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD.</u>			13b. COUNTY <u>CARROLL</u>			13c. CITY OR TOWN <u>WESTMINSTER</u>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First <u>GEORGE W.</u> Middle <u>ZEPP</u> Last <u>ZEPP</u>			15. MOTHER'S MAIDEN NAME First <u>LAURA Z.</u> Middle <u>131st</u> Last <u>131st</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16b. SOCIAL SECURITY NO. <u>4109</u>			17. INFORMANT <u>GEORGE A. ZEPP</u>			ADDRESS <u>WESTMINSTER RD #6 MD.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>4109</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>4201</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4201</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year A.M. <u>19</u> P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Julius Chepko</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <u>12/27/68</u>			
EXAMINER'S NAME (Type) <u>Julius Chepko</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE <u>12/28/68</u>				23c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEMETERY</u>			
				23d. LOCATION (City or Town) (County) (State) <u>WESTMINSTER MD</u>							
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr., Westminster, Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 30 1968</u>				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

